Wellness Update

Patient name	Date of birth	Today's date

How often do you have these symptoms?

(Please check one box in the Severity section and Frequency section)

	SEVERITY			FREQUENCY		
	Mild	Moderate	Severe	Never or Occasionally	Seasonal	Most of the Year/Daily
Watery Eyes	☐	☐	☐	☐	☐	☐
Itchy Eyes	☐	☐	☐	☐	☐	☐
Red Eyes	☐	☐	☐	☐	☐	☐
Runny Nose	☐	☐	☐	☐	☐	☐
Stuffy Nose	☐	☐	☐	☐	☐	☐
Itchy Nose	☐	☐	☐	☐	☐	☐
Frequent Sneezing	☐	☐	☐	☐	☐	☐
Post Nasal Drip	☐	☐	☐	☐	☐	☐
Chronic/Seasonal Colds	☐	☐	☐	☐	☐	☐
Sinus Pressure/Sinus Headache	☐	☐	☐	☐	☐	☐
Dry, Red, or Itchy Skin	☐	☐	☐	☐	☐	☐
Consistent Coughing	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Itchy Mouth / Throat Clearing	☐	☐	☐	☐	☐	☐
Restless Sleep / Snoring	☐	☐	☐	☐	☐	☐
Daytime Fatigue	☐	☐	☐	☐	☐	☐

How often do you use the following?

	Never or Occasionally	Seasonal	Most of the Year/Daily
Over-the-Counter Antihistamine (Allegra®, Claritin® Zyrtec®, Benadryl®, etc)	☐	☐	☐
Over-the-Counter Nasal Spray	☐	☐	☐
Prescribed Allergy Medication/Spray	☐	☐	☐
Neti Pot	☐	☐	☐
Steroids	☐	☐	☐

Patient/Guardian signature	Date	Patient phone

FOR PROVIDER USE ONLY:

Order Allergy Test: ☐ Yes ☐ No

Date of last Physical exam: ___/___/_____

Provider signature: _____

Date: ___/___/_____

Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

PATIENT HISTORY

Medical Conditions		Additional Information
High blood pressure	☐ YES ☐ NO	
Heart Disease	☐ YES ☐ NO	
COPD/Chronic Bronchitis	☐ YES ☐ NO	
Uncontrolled Asthma	☐ YES ☐ NO	
Stroke	☐ YES ☐ NO	
Immune Disorders (HIV, rheumatoid arthritis, cancer, etc.)	☐ YES ☐ NO	

Are you pregnant? ☐ YES ☐ NO ☐ N/A

Do you have the skin condition called ***dermographism***? ☐ YES ☐ NO

Have you ever had a severe anaphylactic (allergic) reaction that required emergency medical attention? If yes, explain: _____ ☐ YES ☐ NO

List **all current medications,** including prescribed and OTC medications:

NAME	TAKEN FOR	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Allergy History

When did allergies begin? (Year) _____

Do symptoms include itching and sneezing? ☐ YES ☐ NO

When do symptoms occur? (check all that apply)

☐ All months

☐ January	☐ April	☐ July	☐ October
☐ February	☐ May	☐ August	☐ November
☐ March	☐ June	☐ September	☐ December

When are symptoms worse?

☐ Morning	☐ Afternoon	☐ Evening	☐ Night
☐ At home	☐ At work	☐ At school	☐ Other location: _____
Symptoms are:	☐ Constant	☐ Occasional	☐ Rare

Symptoms interfere with activities:

☐ Not at all ☐ Mildly ☐ Moderately ☐ All the time

Which of the following cause or make symptoms worse? (Check all that apply)

FOOD

☐ Meat	☐ Wine	☐ Mushrooms	☐ Milk / milk products	☐ Fruit juices
☐ Beer	☐ Cheese	☐ Poultry	☐ Fish	☐ Wheat products
☐ Nuts	☐ Chicken	☐ Vinegar	☐ Eggs/egg products	☐ Vegetables
☐ Liquors				

☐ Other: (list all) _____

Patient Name: _____ Patient DOB: ___/___/___ Date: ___/___/___

ENVIRONMENT

☐ Wind	☐ Smoke	☐ Barns/Hay	☐ High pollution	☐ Damp areas
☐ Soap	☐ Powder	☐ Mowing lawns	☐ Insecticides	☐ Dust
☐ Paint fumes	☐ Perfumes	☐ Cosmetics	☐ Newspapers	☐ Wool
☐ House plants	☐ Weather change	☐ Wet weather	☐ Dry weather	☐ Hot day
☐ Cold day	☐ Air-conditioning	☐ Travel	☐ Furniture	☐ Feather pillows
☐ Hay	☐ Cut grass	☐ Cut flowers	☐ Rugs/rug pads	☐ Christmas trees
☐ Stuffed toys	☐ Other: (list all) _____			

Indoors, explain: _____

Outdoors, explain: _____

PETS

☐ Birds ☐ Cat: Indoor / Outdoor ☐ Dog: Indoor / Outdoor ☐ Cattle ☐ Horse

☐ Other: (list) _____

Place **X** under self or **age** of family members with any of the following medical conditions:

Condition	Self	Father	Mother	Brothers	Sisters	Children
Migraine						
Hay Fever						
Hives						
Eczema						
Asthma						
Food Allergies						

Allergy Care History

List any OTC or Prescribed medications taken for allergy symptoms and when:

NAME	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Other

Have you (patient) had an allergy shot in the last two weeks? ☐ YES ☐ NO If yes, explain _____

Have you (patient) had any vaccine within the last 48 hours? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to latex? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to rubbing alcohol? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to any medications? ☐ YES ☐ NO If yes, explain _____

For Provider Use Only:

NOTES:

_____ _____ ___/___/___

Patient/Guardian Printed Name Patient/Guardian Signature Date

_____ _____ ___/___/___

Provider Printed Name Provider Signature Date

Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

INFORMED CONSENT FOR ALLERGY TESTING

I, _____*(patient name)*, consent to receive an allergy skin prick test by or under the supervision of my provider to help determine the cause of my allergy symptoms.

An allergy skin prick test consists of introducing small amounts of allergens into the skin by lightly scratching the skin with a specially designed applicator containing each allergen and noting any development of a positive reaction. Results are read 15 to 20 minutes after the application of the test. Positive reactions to an allergen will gradually disappear over a period of time.

Reactions from this procedure may occur and I will inform the medical staff of any reactions I may experience. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat, nasal congestion, runny nose, tightness in the throat or chest, increased wheezing, lightheadedness, faintness, nausea or vomiting, generalized itching, bleeding at puncture site, hives and redness of skin. Although rare, under extreme circumstances, serious reactions may result in significant respiratory reactions, or anaphylactic shock, which may be life threatening. I consent and authorize the treatment of any reactions that may occur as a result of allergy testing.

I verify that I am not currently pregnant or if I am, I have discussed the risks/benefits with my provider. Allergy skin testing should be postponed until after the pregnancy. I verify that I am not currently taking beta-blocker medication or if I am, I have discussed risks/benefits with my provider. Beta-blockers are medications that may interfere with treatment of an adverse reaction.

I have been advised that some medications I may be taking could interfere with allergy testing. If it is determined that medication I am taking has interfered with testing data, I understand that testing may need to be repeated at a later time.

I have read this form and I fully understand its contents. The opportunity has been provided for me to ask questions about my allergy skin prick test and these questions have been answered to my satisfaction.

_____	_____	___/___/_____
Patient/Guardian Printed Name	Patient/Guardian Signature	Date
_____	_____	___/___/_____
Witness Printed Name	Witness Signature	Date

Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

ELECTRONIC CONSENT CONTACT FORM

Patients may elect to receive communications via email, mobile text, and phone regarding personal medical information. By allowing the provider to communicate using this method, patients may receive appointment alerts as well as immunotherapy updates. Please be assured that all information will be kept confidential.

By my signature below, I agree that:

1) I would like to receive Short Message Service (SMS) messages and/or email pertaining to my allergy treatment, including, patient appointment or treatment reminders and other allergy related educational information to assist me in my allergy treatment;
2) I would like to receive a SMS message (as described above) through my communication service provider in order to deliver the SMS message to the mobile number listed below;
3) My communication services provider is acting as my agent in this capacity; and
4) I am providing a valid email and/or mobile phone number for these email and/or SMS messaging services.

There are no charges imposed by my provider for SMS message services, but I am responsible for any and all applicable charges or fees imposed by my communications service provider.

Patient Name: _____

Patient/Guardian Signature: _____

Patient E-Mail Address: _____

Patient Mobile Number: _____

Patient Mobile Carrier: _____

Note: *Consent for receipt of email or mobile text messages is not required as a condition of any allergy service or treatment. Consent to receive SMS and/or email notifications may be revoked at any time by following the "opt out" instructions included in the SMS communication copy that is sent to the email address listed. Please allow a reasonable period of time to process your withdrawal. The provider may terminate text and/or email messaging services from time to time, for any reason, and without notice.*

To ensure the accuracy of your results, please refrain from taking the following medications for the time indicated prior to your test.

OMIT 7 DAYS PRIOR TO TEST

Allegra/Allegra D

Astelin

Astepro

Clarinex, Claritin/Clairitin D

Pantanase

Tavist I/Tavist II

Xyzal

Zyrtec

OMIT 3 DAYS PRIOR TO TEST

Actified

Alavert

Atarax

Atrohist

Benadryl

Chlorpheniramine

Chlor-Trimeton

Comhist

Deconamine

Dimetapp

Dramamine

Excedrin PM

Isoclor

Kronofed A/A Jr.

Midol PM

Antidepressants (check with Allergist)

Naldecon

Nolahist

Novahistine

Optimine

Pepcid

Phenergran

Poly-Histine

Ritalin/Focalin

Rondec

Ru-Tess

Tagamet

Teldrin

Tylenol PM

Muscle Relaxers

Sedatives or Tranquilizers

Medications that can be used UNTIL the day of your test:

Tylenol (Regular or Extra Strength)

Birth Control pills

Hormones

Fluid pills

Decongestants (without antihistamines)

Dr. Powell's nasal solution

Nasal steroids (Flonase, Nasonex, Nasocort, Rhinocort)

Some Blood Pressure Medications (check with the Allergist)