

Allergy Testing Questionnaire

First Name

Last name

Date of Birth

(mm / dd / yyyy)

Sex

Male

Female

Allergy Specific Past Medical History

- Seasonal Allergies
- Food Allergies
- Animal Allergies
- Asthma
- Eczema
- Medication Allergies

Family History

- Seasonal Allergies
- Food Allergies
- Animal Allergies
- Asthma
- Eczema

Current Symptoms

- Runny nose
- Scratchy throat
- Itchy Eyes
- Itchy skin
- Cough
- Nighttime cough
- Wheezing
- Anaphylaxis
- Other:

Allergy Testing In The Past

- yes
- No

Allergy Medication Used

- Benadryl
- Atarax
- Claritin or Clarinex
- Zyrtec or Xyzal
- Allegra
- Zantac
- EpiPen
- Albuterol
- ICS (i.e: Flovent, asthmanex, pulmicort)

Date last used oral medications

(mm / dd / yyyy)