Allergy Profile

Name: _____ Phone: _____ DOB: _____ Date: _____

Please check all symptoms that you experience:

☐ Sneezing	☐ Runny Nose	☐ Postnasal Drip	☐ Vomiting
☐ Headaches	☐ Itchy/Watery Eyes	☐ Wheezing	☐ Diarrhea
☐ Nasal Congestion	☐ Shortness of Breath	☐ Itching	

How long have you suffered from these symptoms? _____

When do you experience symptoms? ☐ Daily ☐ Seasonally ☐ Occasionally ☐ Rarely

Have you tried over the counter allergy medication(s) for symptom control? (Antihistamines, nasal sprays, decongestants, etc)?

☐ Yes ☐ No

If yes, which one?

☐ Allegra ☐ Zyrtec ☐ Clarinex ☐ Claritin ☐ Xyzal ☐ Flonase ☐ Benadryl

☐ Other _____

Do the medications listed above help with your symptoms? ☐ Yes ☐ No ☐ Sometimes

Do you suffer from frequent cold and/or sinus infections? ☐ Yes ☐ No ☐ Sometimes

Are there any foods that make your symptoms worse? ☐ Yes ☐ No If yes, which foods?

_____

Provider recommends Allergy Testing? ☐ Environmental ☐ Food ☐ Both Environmental and Food ☐ None

Provider Signature: _____ *Date:* _____

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

PATIENT SCREENING HISTORY

MEDICAL HISTORY AND CURRENT MEDICATION USE

Medical Conditions (Any 'YES' response requires detailed information)

- ☐ YES ☐ NO High blood pressure
- ☐ YES ☐ NO Eosinophilic Esophagitis
- ☐ YES ☐ NO Heart Disease
- ☐ YES ☐ NO COPD/Chronic Bronchitis
- ☐ YES ☐ NO Asthma
- ☐ YES ☐ NO Stroke
- ☐ YES ☐ NO Immune Disorders (HIV, rheumatoid arthritis, cancer, etc.)

For CAS Use Only:

Please document notes detailing discussion with patient here:

Form completed and signed while was patient outside of CAS presence? ☐Yes ☐No

*If yes, CAS reviewed the provided information with the patient and confirmed it is accurate and up to date.

CAS Printed Name Jenna Pratt

CAS Signature _____

Date ___/___/_____

- ☐ YES ☐ NO Do you have the skin condition called ***dermographism***?
- ☐ YES ☐ NO Have you ever had a severe anaphylactic (allergic) reaction requiring emergency medical attention?
  If yes, explain: _____
- ☐ YES ☐ NO Do you (patient) have an allergy to latex?
  If yes, explain: _____
- ☐ YES ☐ NO Do you (patient) have an allergy to rubbing alcohol?
  If yes, explain: _____
- ☐ YES ☐ NO Have you (patient) had any vaccine within the last 48 hours?
  If yes, explain: _____
- ☐ YES ☐ NO Have you (patient) had an allergy shot in the last two weeks?
  If yes, explain: _____
- ☐ YES ☐ NO ☐ N/A Are you pregnant?

Medications: List all current medications, including prescribed and OTC, taken for allergies or other conditions:

NAME	TAKEN FOR	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

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

_____ Patient/Guardian Printed Name

_____ Patient/Guardian Signature

___/___/___ Date

For Provider Use Only (Please select one):

☐ I have reviewed all above information and request the patient proceed with allergy testing and/or allergen immunotherapy

☐ I have reviewed all above information and request additional clinical guidance or information

ADDITIONAL NOTES:

_____ Provider Printed Name

_____ Provider Signature

___/___/___ Date

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

ENVIRONMENTAL ALLERGY HISTORY

If this section was completed during prior visit, check the following box: ☐ Previously completed

If this section does not apply, check the following box: ☐ N/A

When did allergies begin? (Year) _____

What symptoms do you experience? (check all that apply)

☐ Runny Nose	☐ Stuffy Nose	☐ Itchy Nose/Mouth/Throat/Ears	☐ Itchy Eyes
☐ Watery Eyes	☐ Sneezing	☐ Post Nasal Drainage	☐ Sinus Pain/Pressure
☐ Ear Pain/Pressure	☐ Itchy Skin	☐ Rash	

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

ENVIRONMENT

☐ Soap	☐ Powder	☐ Perfumes	☐ Cosmetics	☐ Paint Fumes
☐ Barns/Hay	☐ Mowing Lawns/Cut Grass	☐ Insecticides	☐ Dust	☐ Rugs/rug pads
☐ Furniture	☐ Feather pillows	☐ Stuffed toys	☐ Air-conditioning	☐ Weather change
☐ Dry weather	☐ Wet weather	☐ Hot day	☐ Cold day	☐ Damp areas
☐ Cut flowers	☐ House plants	☐ Christmas trees		

☐ Other: (list all) _____

Indoors, explain: _____

Outdoors, explain: _____

PETS

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

☐ Other: (list) _____

Have you been diagnosed with eczema or atopic dermatitis? ☐ YES ☐ NO

If yes, what do you use if anything to control it: _____

Have you ever been allergy tested? ☐ YES ☐ NO

If yes, when was the last time? _____

Have you ever been placed on immunotherapy (allergy shots, allergy drops or specific prescription of allergy tablets)? ☐ YES ☐ NO

If yes, what type were you on? _____

How long were you on immunotherapy? _____

Did immunotherapy help? _____

Were there any issues while on immunotherapy? ☐ YES ☐ NO

If yes, please explain: _____

Any adverse effects while on any medication? ☐ YES ☐ NO

If yes, what medication(s) and what occurred: _____

Do you utilize a HEPA air purifier, HEPA HVAC air filter or other HEPA filtration device in your current residence? ☐ YES ☐ NO

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 symptoms and/or reactions. An allergy skin prick test consists of introducing small amounts of allergens onto 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 appear as a raised bump or wheal, and then 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 procedure 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 skin prick 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 been advised that the allergy test may need to occur on my back. If this occurs, I will need to remove any clothing covering my back in order to expose my bare skin for the testing. I will be provided a gown for my comfort, as well as have the option for a chaperone to be present along with the person doing my testing.

- ☐ **YES,** I elect to have a chaperone present
- ☐ **NO,** I waive the opportunity to have a chaperone present
- ☐ **I do not wish to have any testing placed on my back**

FOR CAS USE ONLY:
Name of Chaperone:_____

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
		/ /

FOR CAS USE ONLY:
Form signed and witnessed outside of CAS presence? ☐Yes ☐No
*If yes, CAS reviewed the content of the form with the patient/parent/guardian and has answered all questions posed.

CAS Name: Jenna Pratt 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.*