MOUNT HOLYOKE

MOUNT HOLYOKE COLLEGE

Health Services Allergy Immunotherapy Intake

Name: ________________________________ DOB: _________ Class Year: _______

What are you allergic to? Note the results of Allergy Testing: _____________________

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What triggers your allergy symptoms? ____

____

What symptoms do you have during allergy season? ____________________________

____

When did you first begin allergy injections? ____________________________________

Have the allergy injections helped your symptoms? _____________________________

Following allergy injections have you had any of the following? Please circle:

asthma wheezing hives rashes runny nose itching

swelling at the site abrupt onset of abdominal symptoms (diarrhea, vomiting)

How do you manage the above reactions? ____________________________________

____

Have you ever had a severe reaction following your allergy injections? Yes No

If yes, explain: ____

Have you ever been seen at an Emergency Room for an allergic reaction? Yes No

If yes, explain: ____

Do you take an antihistamine before receiving allergy injections? ____________

Do you monitor your Peak Flow? Yes No If yes, what is your best value? _________

Other Medical History:
List any medications that you take, prescription and over the counter:

List any allergies or negative reactions to any medications:

List any chronic health conditions (ie asthma, migraines, bowel disorders, skin conditions):

Patient's Signature:______________________________________ Date:_____________

Nurse's Signature:_______________________________________ Date:_____________