Wellness History

Patient name	Date of birth	Today's date

How often do you have these symptoms?

	Never	Occasionally	Daily	Seasonally
Watery / Itchy Eyes	☐	☐	☐	☐
Runny / Stuffy Nose	☐	☐	☐	☐
Itchy Nose	☐	☐	☐	☐
Seasonal Colds	☐	☐	☐	☐
Chronic Colds	☐	☐	☐	☐
Sinus Pressure / Pain	☐	☐	☐	☐
Post Nasal Drip	☐	☐	☐	☐
Frequent Sneezing	☐	☐	☐	☐
Consistent Coughing	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Itchy Mouth / Throat Clearing	☐	☐	☐	☐
Dry, Red, or Itchy Skin	☐	☐	☐	☐
Tension / Migraine Headaches	☐	☐	☐	☐
Restless Sleep / Snoring	☐	☐	☐	☐
Daytime Fatigue	☐	☐	☐	☐

How often do you use the following?

	Never	Occasionally	Daily
Over-the-Counter Antihistamine (Allegra®, Claritin® Zyrtec®, Benadryl®, etc)	☐	☐	☐
Over-the-Counter Nasal Spray	☐	☐	☐
Prescribed Nasal Spray	☐	☐	☐
Neti Pot	☐	☐	☐
Headache Medicine	☐	☐	☐

Patient/guardian signature	Date	Patient phone

FOR CAT/CAS USE ONLY

Date of Last Physical Exam__/__/___

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: _____DOB:____/____/_____Date:____/____/_____

INFORMED CONSENT FOR ALLERGY TESTING

I, _____(patient name), consent to receive an allergy skin prick test under the supervision of my provider to help determine what I am allergic to.

An allergy skin prick test consist of 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 acknowledge 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 acknowledge that I am not presently taking a beta-blocker medication or if I am, I have discussed risks/benefits with my provider. I understand that these medications are commonly used to treat high blood pressure, arrhythmias, heart palpitations, tremors, glaucoma and migraine headaches. They may increase my risk for a systemic reaction that is resistant to treatment.

I have been counselled 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.

_____	_____	___/___/____
Printed/Gaurdian Printed	Patient/Gaurdian Signature	Date