STAMPS HEALTH SERVICES
Allergy Prescreening Questionnaire

Date: ____________ Email: ______________________
Name: ___________________ GT ID #: ______________________
DOB/age: ___________________ Phone # (local): ______________________
(Cell): ______________________

1. For what reasons are you receiving allergy shots?
Seasonal Allergies ________ Asthma ________ Skin Allergies ________

2. What medications does your allergist prescribe for you to take for your allergies?
_________________________________________________________________

3. What medications do other doctors prescribe for you and why?
_________________________________________________________________

4. What over the counter medications do you take routinely?
_________________________________________________________________

5. Do you have any lung or heart problems? If so, please explain.
_________________________________________________________________

6. Do you have any allergies to medications? Please list:______________________

7. How long have you been receiving allergy shots? _________________________

8. When was your last allergy shot? _______ Was this shot given on time? _______

9. Was there any swelling at the injection site after your last shot? ______________

10. Have you ever had a serious reaction after your allergy injection such as shortness of
breath, wheezing, or swelling? Hospitalization or intubation?
_________________________________________________________________

11. If yes to the above question, please explain_______________________________
_________________________________________________________________

12. Have you had any breathing problems over the past 7 days? _______________

Nursing Staff only: (Please initial each requirement below when it is completed.)

___ The patient is being treated by a board certified U.S. allergist.
___ If the allergist orders have requirements that cannot be met by our Health
  Services, the allergist office must be notified. We must receive new orders that
  meet our capabilities before immunotherapy can begin.
___ Meet requirements for allergy immunotherapy administration.
___ New orders obtained from allergist office that meet our capabilities for
  administration.

Date of Effective Revision # 120- 6122012