

## Allergen Immunotherapy Pre-Injection Questionnaire

Patient Name \_\_\_\_\_ Chart Number: \_\_\_\_\_  
Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

***This questionnaire is designed to optimize safety precautions already in place for your allergen immunotherapy injection(s) (allergy shot).***

*Please review and answer the following questions. The nursing staff will review your responses and notify your physician if they have any questions or concerns about whether you should receive your injection(s) today.*

*Please circle the appropriate answer for each question.*

1. I have confirmed that the name and birth date on my immunotherapy vial(s) are correct. **Yes No**
2. In the past week have you had
  - a. Increased asthma symptoms **Yes**  
**No** (chest tightness, increased cough, wheezing, or shortness of breath)? or
  - b. Increased allergy symptoms **Yes**  
**No** (itching eyes or nose, sneezing, runny nose, post-nasal drip, or throat-clearing)?
4. In the past two weeks have you had a cold, respiratory tract infection or flu-like symptoms? **Yes**  
**No**
5. Did you have any problems such as increased allergy or asthma symptoms, hives, or **Yes**  
**No** generalized itching within 12 hours of receiving your last injection?
6. Are you on any new medications? Any new eye drops? **Yes No**  
If yes, please specify. \_\_\_\_\_
7. Have you been diagnosed with a new medical condition? **Yes No**  
If yes, please describe: \_\_\_\_\_
8. Are you pregnant? **Yes No**

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### This section for Staff use only

Please note Staff intervention for this visit

none required

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Staff Signature: \_\_\_\_\_



## **Allergen Immunotherapy Pre-Injection Questionnaire**

When reordering serum **please fax all three of the following forms to 952-681-7878.**

1. Allergy Injection Schedule 2. Serum Refill Consent & Order Form 3. This form.

Forms may be downloaded from our website @ [mw.allergy.com](http://mw.allergy.com)

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