Allergy Clinic Intake
University Health Services
University of Massachusetts
Amherst, MA 01003
413-577-5000

Name: __________________________ Date: __________________________
E-mail address: __________________________ Cell number: __________________________
Local address: __________________________
________________________________________
________________________________________

DOCTOR PRESCRIBING ALLERGY SERUM AND ORDERS
Name: __________________________
Address: __________________________
________________________________________
Telephone: __________________________

1. How long have you been receiving allergy injections? __________________________

2. When were you last evaluated by your allergist? __________________________

3. Have you ever had a severe or anaphylactic reaction to your allergy injections?  ○ yes  ○ no
   If yes, list symptoms and how soon after the injection they occurred: __________________________
   __________________________________________________________
   __________________________________________________________

4. Do you have asthma?  ○ yes  ○ no

5. Do you have medication allergies?  ○ yes  ○ no
   If yes, list: __________________________________________________
   __________________________________________________________
   __________________________________________________________

6. Do you have food allergies?  ○ yes  ○ no
   If yes, list: __________________________________________________
   __________________________________________________________
   __________________________________________________________

7. List medications currently used, including inhalers and nasal sprays: __________________________
   __________________________________________________________
   __________________________________________________________

8. List any other allergy-related problems experienced: __________________________
   __________________________________________________________
   __________________________________________________________

UHS M.D. reviewed: __________________________ Date: __________________________

(Signature)