



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

L	Last Name: _____ MRN # _____
A	First Name: _____ MI: _____
B	DOB: _____ Sex: _____
E	Date of Service: _____ Visit # _____
L	Provider: _____

Name: _____ Date: _____
 E-mail address: _____ Cell number: _____
 Local address: _____

DOCTOR PRESCRIBING ALLERGY SERUM AND ORDERS

Name: _____
 Address: _____

Telephone: _____ Fax: _____

- How long have you been receiving allergy injections? _____
- When were you last evaluated by your allergist? _____
- 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: _____

- Do you have asthma? yes no
- Do you have medication allergies? yes no
 If yes, list: _____

- Do you have food allergies? yes no
 If yes, list: _____

- List medications currently used, including inhalers and nasal sprays: _____

- List any other allergy-related problems experienced: _____

UHS M.D. reviewed: _____ Date: _____
 (signature)