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

LABEL	
	Last Name: _____ MRN #_____
	First Name: _____ MI: _____
	DOB: _____ Sex: _____
	Date of Service: _____ Visit # _____
	Provider: _____

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)