Immunotherapy Pre-Injection Questionnaire

Patient Name:_____ 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. **If you are pregnant or have been diagnosed with a new medical condition, please notify the staff.** (Please circle the appropriate answer.)

I have confirmed that the name and birth date on my immunotherapy vial(s)are correct **yes no**

1. Have you had increased asthma symptoms (chest tightness, increased cough, wheezing, or shortness of breath) in the past week? **Yes No**

2. Have you had increased allergy symptoms (itching eyes or nose, sneezing, runny nose, post-nasal drip, or throat-clearing) in the past week? **Yes No**

3. Have you had a cold, respiratory tract infection, or flu-like symptoms in the past two weeks? **Yes No**

4. Did you have any problems such as increased allergy or asthma symptoms, hives, or generalized itching within 12 hours of receiving your last injection? **Yes No**

5. Are you on any new medications? Any new eye drops? Please specify._____

Staff intervention/office visit:

_____

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Staff Signature:____