Medical History

Patient Name: _____ DOB: _____

Date: _____

1. Are you pregnant? YES / NO
2. Have you tested positive for HIV? YES/ NO
3. Have you ever had a stroke? YES / NO
4. Have you ever been diagnosed with or do you have a history of cardiovascular disease? YES / NO
5. Are you on any blood pressure medication? YES / NO
   If yes, please state which medications: _____
6. Are you on any heart medication? YES / NO
   If yes, please state which medications: _____
7. Have you ever had a severe anaphylactic reaction *(severe allergic reaction)* that required emergency medical attention? YES / NO
8. Do you have uncontrolled asthma? YES / NO
9. Within the past year have you had an allergy scratch test? YES / NO
10. Within the past year have you had Immunotherapy Medication made for you? YES / NO
11. Do you have a history of taking any allergy medications including allergy shots? YES / NO
    If yes, please state what type: _____

If there is a possibility that you are pregnant please notify the provider before you have the allergy test.

_____ _____
Patient Signature Date

Office Use Only

Provider Notes: _____

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_____ _____
Provider Signature Date