PRE-ALLERGY INJECTION EVALUATION:

Date: _____

Name: _____

1. Please confirm that your name is on your vials before you receive your Allergy shot _____ (Patient initial that vials confirmed)

2. How are you feeling today? _____
    a. If you are acutely sick, you should not receive allergy injections.
    b. If you have asthma and are feeling more short of breath than usual, you should not receive an allergy injection. Return for an injection when you feel better.

3. Did you have any delayed local arm reaction bigger than a quarter? _____

4. Did you have any generalized reactions after your last injection? _____
    a. Large arm reactions and acute flare ups of your allergy Symptoms may lead to lowering the dose of your allergy injection.

5. Are you carrying your Epinephrine Auto injector? _____

6. Please be aware that if you are pregnant, you should discontinue your allergy shots.

7. Are you taking any new medications? _____
    a. You may not take allergy injections if you take Beta Blockers and some antidepressants (MAO Inhibitors).

Patient Signature: _____

Date: _____