Medical History

Date: _____

Patient Name: _____DOB: _____

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

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 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 physician before you have the allergy test.

_____ _____
Patient Signature Date

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Office Use Only

Provider Notes:_____

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_____ _____
Provider Signature Date