Justin Clark, D.O., F.A.A.A.A.I.
ALL SEASONS ALLERGY & ASTHMA CENTER
Advanced care to help you breathe better... *for life.*

Immunotherapy Pre-Injection Questionnaire

Patient Name: _____ **Date:** _____
Patient DOB: _____

This questionnaire is designed to optimize safety precautions already in place for your allergen immunotherapy injection(s) ("allergy shots"). Please review and answer the following questions. The staff will review your responses and notify your health care provider if they have any questions or concerns about whether you should receive your injection(s) today. **If you are pregnant, prescribed any new medications or have been diagnosed with a new medical condition, please notify the staff.**

(Please circle the appropriate answer)

1. Have you had increased asthma symptoms (chest tightness, increased cough, wheezing, or shortness of breath) in the past week? (circle all that apply) **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? (circle all that apply) **YES NO**

3. Have you had a cold, respiratory tract infection, or flu-like symptoms in the past two weeks? (circle all that apply) **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 or swelling that persisted into the next day? (circle all that apply) **YES NO**

5. Are you on any new medications since the last time you had a shot? Any new eye drops or heart medications? **YES NO**
   If yes, please specify:_____

6. Did you take an antihistamine today? **YES NO**

7. Will you be receiving cluster immunotherapy today? **YES NO**
   Cluster immunotherapy is an accelerated administration schedule that is used during the early stages of the build-up. Therefore, it's an option for patients receiving shots from their silver, green or blue vials. Please remember that you must arrive to the clinic between 8:00-9:30 a.m. or 1:00-2:30 p.m. and remain in the clinic for a total of 2 hours.

8. Do you consent to receive immunotherapy (allergy shots)? **YES NO**

Staff notes:

_____

_____

Medical Staff Signature: _____ Date: _____

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