Allergy Treatment Release and Waiver

The undersigned acknowledges that Dr. Heather Wojslaw, who practices medicine as a staff member of PROLEAN WELLNESS, LLC., has advised me of the potential risks associated with the administration of the allergy serum, which has been prescribed for my use. I was instructed in the administration of the serum. The undersigned further acknowledges that I have been advised of the potential benefits of the allergy serum. I have considered both the risks and the benefits of the treatment and have determined that the benefits outweigh the potential risks. Based upon my desire to have the allergy serum prescribed for me, I hereby release and waive any claim, cause or action against Prolean Wellness, LLC and/or staff members due to any reactions I may suffer from the allergy serum, provided such reactions are not due to negligence or other inappropriate acts of the doctor or staff members.

Print patient's name

_____ Date: _____

Patient's
Signature_____

Parent/Guardian
Signature _____
(if patient is younger than 18years)

Allergy History Survey

Name_____Occupation_____Age__
_____

COMPLAINTS: Please circle the appropriate number 1-5 according to severity: 1 = mild, 5 = very severe, 0 = no problem:

Nasal discharge 0 1 2 3 4 5

Chronic fatigue 0 1 2 3 4 5

Nasal obstruction 0 1 2 3 4 5

Food intolerance 0 1 2 3 4 5

Watery or itchy eyes 0 1 2 3 4 5

Frequent sinus or ear infection 0 1 2 3 4 5

Sneezing 0 1 2 3 4 5

Frequent colds or sore throats 0 1 2 3 4 5

Wheezing 0 1 2 3 4 5

Learning disability 0 1 2 3 4 5

Cough 0 1 2 3 4 5

Poor memory or concentration 0 1 2 3 4 5

Itching 0 1 2 3 4 5

Hyperactivity 0 1 2 3 4 5

Eczema 0 1 2 3 4 5

Abdominal gas or cramping 0 1 2 3 4 5

Hives 0 1 2 3 4 5

Arthritis or muscle aching 0 1 2 3 4 5

Headache 0 1 2 3 4 5

Asthma 0 1 2 3 4 5

Other symptoms

_____

Which (if any) foods cause you any problems?

_____

In what year did your allergies start?

_____

How many months of the year do you have allergies?

_____

Have you been allergy tested before? _____ If yes, did you receive desensitization shots?

_____

What prescription medications have you tried for allergies? How long did you use them?

1. _____For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

Does any medication give you relief of symptoms?

_____

List any animals you have in or around the
home_____

Who else in your family has allergies?

_____

How did you hear about our office? (Be specific. If a newspaper, please give name)

Allergy Progress Survey

Name _____ Date_____

COMPLAINTS: Please circle the appropriate number 1-5 according to severity: 1 = mild, 5 = very severe, 0 = no problem

Nasal Discharge 0 1 2 3 4 5
Chronic Fatigue 0 1 2 3 4 5
Nasal Obstruction 0 1 2 3 4 5
Food Intolerance 0 1 2 3 4 5
Watery or itchy eyes 0 1 2 3 4 5
Frequent sinus or ear infection 0 1 2 3 4 5
Sneezing 0 1 2 3 4 5
Frequent colds or sore throats 0 1 2 3 4 5
Wheezing 0 1 2 3 4 5
Learning disability 0 1 2 3 4 5
Cough 0 1 2 3 4 5
Poor memory or concentration 0 1 2 3 4 5
Itching 0 1 2 3 4 5
Hyperactivity 0 1 2 3 4 5
Eczema 0 1 2 3 4 5
Abdominal gas or cramping 0 1 2 3 4 5
Hives 0 1 2 3 4 5
Arthritis or muscle aching 0 1 2 3 4 5
Headache 0 1 2 3 4 5
Asthma 0 1 2 3 4 5
Other
Symptoms_____

Other Comments/Concerns about progress on the program so far:

_____