Allergy Treatment Release and Waiver

The undersigned acknowledges that _____,

Who practices medicine as a staff member of _____,

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 herby release and waive any claim, cause, or action against _____ 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 _____

Patient's signature _____ Date _____

Parent/Guardian Signature

(if patient is younger than 18 years) _____ Date _____

Allergy History Survey

Name _____ **Date**_____

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? _____

4. _____ 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:

_____

_____

_____

_____

_____