



Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

<u>Patient To Complete</u>	<u>Doctor Use</u>
1. Main symptoms for investigation:	
2. Do you suffer from (Please tick):	
<input type="checkbox"/> Asthma/Shortness of breath	
<input type="checkbox"/> Nasal/sinus symptoms	
<input type="checkbox"/> Eye symptoms	
<input type="checkbox"/> Food reactions	
<input type="checkbox"/> Skin rashes	
<input type="checkbox"/> Headaches	
<input type="checkbox"/> Other	
3. Please list all medications:	
4. What medications have you tried?	
5. Do your symptoms vary during the year?	
6. Family history of allergy?	
7. What triggers the symptoms?	
8. Do any foods cause symptoms?	
9. Have you had previous allergy testing/injections?	
10. Any additional information?	