1190 N Spring Creek Place Suite E1 ● Springville, UT 84663 ● P: 1-844-693-7677 ● Fax: 1-800-496-7219

Please fill this form out and fax to 1-800-496-7219 OR email to customerservice@myallergydrops.com

Patient Name: _____ Todays Date: _____

Date of Birth: _____ Phone Number: _____

Weight: _____

Allergy Review of Symptoms: (Please check all that apply)

□ Sneezing	□ Runny Nose	□ Post Nasal Drip	□ Nasal Congestion
□ Hoarseness	□ Scratchy Throat	□ Itchy Mouth	□ Red/Watery Eyes
□ Itchy Eyes	□ Itchy Ears	□ Eczema	□ Rashes/Hives

Frequency/Time of Symptoms: (Please check all that apply)

□ Sporadic (at various times of the year but with no pattern)
□ Persistent (throughout the year)
□ Seasonal (if seasonal, indicate the prominent months below)

□ January	□ February	□ March	□ April	□ May	□ June
□ July	□ August	□ September	□ October	□ November	□ December

Allergy Triggers: (Indicate where/when symptoms occur)

□ After Mowing	□ In Damp Areas	□ Out Walking	□ While Exercising
□ Near Farms	□ In Basement	□ In Bed	□ In Kitchen
□ In Attic	□ Around Cats	□ Around Dogs	□ Around Horses
□ While Gardening	□ Other _____		

□ Food (List all suspected or known triggers)

_____

_____

Current Medications (All medications, including allergy medications and over the counter):

_____

_____

_____

_____

Additional Questions:

□ Yes □ No Are you currently pregnant?
□ Yes □ No Do allergy medications help relieve your symptoms?
□ Yes □ No Have you ever had an *anaphylactic reaction?
□ Yes □ No Have you been allergy tested within the past year?
□ Yes □ No Have you ever had allergy shots or taken allergy drops?
□ Yes □ No Are you currently taking any *beta blockers?
□ Yes □ No Are you currently being treated for asthma?

What medications are you currently taking for asthma? _____

Do you use a rescue inhaler? _____ How often? _____

In the past year have you required an oral steroid for asthma? _____

Do you use a peak flow meter? _____ If "yes", what is your typical peak flow (liter/min)? _____

*Anaphylactic reaction – severe reaction characterized by difficulty breathing due to throat swelling and/or loss of consciousness.

*Beta Blockers – Propanolol, Sotalol, Timolol, Pindolol, Levobunolol, Nadolol, Metipranolol, Atenolol, Acebutolol, Metoprolol, Bisoprolol, Esmolol, Betaxolol, Nebivolol.