Patient Name:

 DOB:

### CLINIC NAME / LOGO

## Advanced Allergy Care Questionnaire

# Please Check Any Box That Applies

[ ]  History of anaphylaxis during allergy immunotherapy (allergy shots)

[ ]  Failed allergy immunotherapy in the past

[ ]  Hospitalized for allergies in the past year

[ ]  Steroid injection for allergies in the past 3 months

[ ]  Uncontrolled, severe asthma

[ ]  Heart failure

[ ]  Renal disease

[ ]  Chronic obstructive pulmonary disease (COPD)

[ ]  Untreated anxiety

[ ]  Severe, untreated depression

[ ]  Currently undergoing cancer treatment

[ ]  Pregnant

[ ]  Actively trying to get pregnant

[ ]  Taking immunosuppressant medication

|  |  |
| --- | --- |
| For Office Use Only: |  |
| [ ]  Refer to Specialist | [ ]  In-Office Treatment |