Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

PATIENT SCREENING HISTORY

MEDICAL HISTORY AND CURRENT MEDICATION USE

Medical Conditions (Any 'YES' response requires detailed information)

- ☐ YES ☐ NO High blood pressure
- ☐ YES ☐ NO Eosinophilic Esophagitis
- ☐ YES ☐ NO Heart Disease
- ☐ YES ☐ NO COPD/Chronic Bronchitis
- ☐ YES ☐ NO Asthma
- ☐ YES ☐ NO Stroke
- ☐ YES ☐ NO Immune Disorders (HIV, rheumatoid arthritis, cancer, etc.)

For CAS Use Only:

Please document notes detailing discussion with patient here:

Form completed and signed while was patient outside of CAS presence? ☐Yes ☐No

*If yes, CAS reviewed the provided information with the patient and confirmed it is accurate and up to date.

CAS Printed Name_____

CAS Signature _____

Date ___/____/_____

☐ YES ☐ NO Do you have the skin condition called ***dermographism***?

☐ YES ☐ NO Have you ever had a severe anaphylactic (allergic) reaction requiring emergency medical attention?
If yes, explain: _____

☐ YES ☐ NO Do you (patient) have an allergy to latex?
If yes, explain: _____

☐ YES ☐ NO Do you (patient) have an allergy to rubbing alcohol?
If yes, explain: _____

☐ YES ☐ NO Have you (patient) had any vaccine within the last 48 hours?
If yes, explain: _____

☐ YES ☐ NO Have you (patient) had an allergy shot in the last two weeks?
If yes, explain: _____

☐ YES ☐ NO ☐ N/A Are you pregnant?

Medications: List all current medications, including prescribed and OTC, taken for allergies or other conditions:

NAME	TAKEN FOR	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Do you (patient) have an allergy to any medications? ☐ YES ☐ NO If yes, explain:_____

_____ Patient/Guardian Printed Name

_____ Patient/Guardian Signature

___/___/____ Date

For Provider Use Only (Please select one):

☐ I have reviewed all above information and request the patient proceed with allergy testing and/or allergen immunotherapy

☐ I have reviewed all above information and request additional clinical guidance or information

ADDITIONAL NOTES:

_____ Provider Printed Name

_____ Provider Signature

___/___/____ Date