MERCY UNIVERSITY

ALLERGY INJECTION MEDICAL HISTORY FORM

Patient Information		
Name	Date of Birth	Date
Best Contact #		Other Contact #
Emergency Contact Information		
Name		Relationship
Best Contact #		
_____ YES ____NO Can we share details with this contact about your medical condition in an emergency?		
Allergist Information		
Name		Phone #
Medical Information Update		
List current medications		List any medication allergies
History of Asthma Yes _____ No_____		If yes, please describe
History of serious reaction to allergy injection Yes _____ No_____		If yes, please describe
Any changes in health status in the past year Yes _____ No_____		If yes, please describe
History of, or are you now taking beta-blockers Yes _____ No_____		If yes, please describe
CLINICAL USE ONLY: Review annually, use a new form for any changes		
Date:	Reviewed (print name)	Signature