Allergy Questionnaire and Consent for Patients Undergoing Skin Testing

Circle the correct response or fill in the blank

1. Do you live in a CITY, SUBURB, or RURAL AREA/FARM?
2. Do you live in a HOUSE, APARTMENT, OR CONDO/TOWNHOUSE?
3. Approximately how old is the place you are living in? ____ years.
4. Do you have pets? Yes No
5. If yes, how many:
   Dogs_____ Cats _____ Birds_____ Other _____
6. Are there any smokers in your home? Yes No
7. Have you ever had problems with any of the following:

Water leaks or mold?	Yes	No
Roaches?	Yes	No
Mice or roof rats?	Yes	No

8. Not including the child being seen today, does anyone else in your family have:

Seasonal allergies?	Yes	No
Sinus problems?	Yes	No
Bad reactions to bee stings?	Yes	No
Bad reactions to any drug, like penicillin or sulfa?	Yes	No
Asthma	Yes	No
Bad reactions to foods, like peanuts or shell fish?	Yes	No
Eczema?	Yes	No

9. Has the child being seen today seem to frequently suffer from any of the following?

Coughing?	Yes	No	Ear pain?	Yes	No	Congestion?	Yes	No
Sore throat?	Yes	No	Itchy/red eyes?	Yes	No	Sinus pain?	Yes	No
Wheezing?	Yes	No	Constipation?	Yes	No	Nausea?	Yes	No
Rashes?	Yes	No	Stomach pain?	Yes	No	Diarrhea?	Yes	No
Bloating after meals?	Yes	No	Swelling of the eyes, tongue or throat?				Yes	No
Vomiting after meals?	Yes	No	Tingling of the mouth or any other sensation?				Yes	No
Difficulty breathing?	Yes	No	Itchy skin?	Yes	No	Hives?	Yes	No

Allergy skin testing is an important diagnostic tool to determine the source of allergic reaction(s). Correct identification of what triggers allergic symptoms helps medical providers to determine the best treatment options.

The skin test involves placing multiple antigens on the patient's back (or other part of the body). The skin will react only to those antigens that the patient is allergic to. The reaction site may itch or be red/irritated for a short time period. In extremely rare instances, anaphylaxis may occur. However, skin testing is considered to be a very low-risk diagnostic test. The cost varies by health plan. Please know your insurance deductibles, co-insurance or co-pays.

By signing below you are confirming you understand the reasons for the test, as well as the potential benefits/risks involved.

_____(Parent/Patient) _____(Date)