

Insect Sting Allergy – Initial Evaluation



Circle if you have:

ANA kit Epi Pen Sr Jr Anaguard

Has proper use been demonstrated? Yes No

Have you actually given a shot? Yes No Provider initials: _____

Patient please fill out:

ALL ASTHMA/ALLERGY MEDICATIONS Include nasal sprays and inhalers, prescription and over-the-counter	# of mg, tabs, caps or puffs	Times/day	ALL OTHER MEDICATIONS AND DOSAGES	# of mg, tabs, caps or puffs	Times/day

Previous allergy or asthma medications (include over-the-counter): _____

Review of symptoms:

Please check if present RECENTLY.

1. GENERAL: fever sweats weight change none other: _____
2. SKIN: rash hives unusual mole none other: _____
3. EYES: redness itching vision change none other: _____
4. EARS: plugged infection ringing none other: _____
- NOSE: sneezing bleeding polyps none other: _____
- MOUTH: soreness toothache hoarseness none other: _____
5. LUNGS: cough wheeze sputum production none other: _____
6. HEART: chest pain murmur leg swelling none other: _____
7. ABDOMEN: vomiting bloody stool food allergy none other: _____
8. URINARY: burning bloody urine prostate problems none other: _____
9. IMMUNE: bruising swollen glands recurrent colds none other: _____
10. PSYCH: depression anxiety mood swings none other: _____

OTHER: _____

Provider Initials: _____

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Past Medical History

HOSPITALIZATIONS

Age or Year	Illness

Physician/Nurse Notes

SURGERIES

Circle: Tonsillectomy Adenoidectomy Ear tubes

Sinus/nasal surgery Other: _____

EMERGENCY VISITS

_____ times in past year for _____

_____ times in past 5 years for _____

CHRONIC HEALTH CONDITIONS

Circle: Hypertension Diabetes GERD (reflux) Heart disease

Migraines Depression Other: _____

_____ since _____

_____ since _____

SOCIAL HISTORY

Occupation/School grade: _____

Where and how long: _____

Symptoms at work: _____

Hobbies: _____

Level of education: _____

Travel in past year? Where? _____

In daycare? Yes No Where? _____

Animals there? Yes No Smokers? Yes No

Other relevant social factors: _____

MARITAL STATUS

- Single
- Married
- Divorced
- Widowed
- Separated

LIFE STRESS

- Family
- Financial
- School
- Work
- Nervous tension

HISTORY OF:

- Hepatitis
- Blood transfusion
- HIV (AIDS test)
- Recreational drugs
- Alcohol use

YES NO

-
-
-
-
-

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SOCIAL HISTORY, CONTINUED

SMOKING
<input type="checkbox"/> Never smoked
<input type="checkbox"/> Current smoker
<input type="checkbox"/> Former smoker
<input type="checkbox"/> Other tobacco
Packs/day: _____
Years smoked: _____
Date quit: _____

RECENT	YES	NO
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>
Sinus X-ray	<input type="checkbox"/>	<input type="checkbox"/>
Cat scan	<input type="checkbox"/>	<input type="checkbox"/>
TB (PPD) test	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia shot	<input type="checkbox"/>	<input type="checkbox"/>
Flu shot	<input type="checkbox"/>	<input type="checkbox"/>
If child, vaccines current?	<input type="checkbox"/>	<input type="checkbox"/>

PAST ALLERGIES

Circle: Hay fever Asthma
 Eczema Hives
 Food Allergy Latex Allergy

Family members with sting allergy? Yes No

Hobbies that may cause increased exposure to insects:

(List) _____

FAMILY HISTORY

	Allergies	Asthma	Frequent Coughing	Frequent Infections	Alive	Deceased
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s) # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s) # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandfather(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandmother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List other chronic conditions such as eczema, sinusitis, hives, cystic fibrosis, emphysema, cancer, diabetes, etc: _____

Goals for visit today? _____

PROVIDER SUMMARY:

Provider Initials: _____