

Insect Sting Allergy – Re-Testing



Please fill-out this entire form and bring it with you to your appointment.

Form completed by: patient spouse parent or guardian

Name: _____

Appointment Date: _____ R.N.: _____

1. Description of original reaction and when it occurred:

2. When were shots started, and have they been regular? Any reactions?

3. Have there been subsequent stings, and if so, by what insect? Describe reaction.

Circle if available: ANA kit EpiPen Sr EpiPen Jr Anaguard

Has it ever been used? Yes No

Has proper use been demonstrated? Yes No

Have you ever actually administered a shot? Yes No

4. Name and address of present family doctor:

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Patient name: _____ Date of birth: _____

Appointment date: _____ Referred by: _____

Referring physician's address: _____

When did sting reaction occur? _____

What activity was being performed? _____

Describe the insect: _____

Did it leave a stinger? Yes No

Circle where the insect came from:
Ground nest Hanging nest Flowers/bushes Grass

Describe nest: _____

Describe reaction: _____

Physician/Nurse Notes

Circle symptoms:

SKIN

Itching all over
Redness of body
Hives all over
Swelling of body

BREATHING

Shortness of breath
Tight throat
Asthma
Hoarseness

ABDOMINAL

Nausea
Vomiting
Cramping
Diarrhea

HEART

Lightheadedness
Fainting
Collapse
Unconsciousness

Did it require visit to: Hospital? Doctor's office?

Circle medicines used:

Antihistamine
Adrenalin (Epinephrine)
Steroids (Prednisone)
IV (intravenous)
Oxygen

What were **previous** sting reactions like? _____

Have there been **subsequent** stings? What happened? _____

Has patient been on insect allergy shots before? Yes No

If so, for how long? _____

Circle if you have:

ANA kit Epi Pen Sr Jr Anaguard

Has proper use been demonstrated? Yes No

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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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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: _____