INSECT ALLERGY - *Honey bee, wasp, yellow jacket, hornet, fire ant*

Patient Name:_____ *DOB*_____

Appointment Date/Time:_____

Referring Physician:_____

Physician's Address:_____

Please fill out this side and bring it with you to your appointment.

Notes

Form Completed by: Patient □ Spouse □ Parent /Guardian □

Date of sting/bite ?____/____/____ When did reaction occur?_____

What activity was being performed?_____

Describe the insect:_____

Did it leave a stinger? Yes □ No □

Did insect come from (circle):

Ground nest Hanging nest Flowers/bushes Grass

Describe nest: _____

Describe reaction:_____

_____

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: (circle): Hospital Doctor's office

Medicines used: (circle):
- Antihistamine
- Adrenalin (Epinephrine)
- Steroids (Prednisone)
- IV (Intravenous)
- Oxygen

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

Have there been **subsequent** stings/bites - what happened?_____

Has patient been on insect allergy shots before? Yes □ No □

If so, for how long?_____

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