INITIAL ALLERGY EVALUATION

Patient Name: _____Phone number_____

Patient Date of Birth: _____ Date: _____

	YES	NO
Do you have symptoms, or have you ever had symptoms, such as sneezing, watery nasal discharge, throat itching or dry mouth?	_____	_____
Do you have, or have you ever had, frequent "colds", sinus problems or chronic nasal congestion including headaches?	_____	_____
Do you have, or have you ever had, your eyes itch, water, get red or swell?	_____	_____
Do your symptoms get worse in certain seasons?	_____	_____
Are your symptoms worse around animals?	_____	_____
Do you have, or have you ever had asthma, eczema or hives?	_____	_____
Do you suspect that you have sensitivities to foods?	_____	_____
Do you have or ever had chronic pain or swelling/inflammation?	_____	_____

FOR PHYSICIANS USE ONLY

ORDER FOR ALLERGY TESTING AND TREATMENT IF INDICATED
___95004 PRICK TESTING ___ 86003 Blood Spot Testing IgE
___95165 TREATMENT
ICD – 10 DIAGNOSIS CODE: J30.1 ALLERGIC RHINITIS DUE TO POLLEN T78.40XA ALLERGY UNSPECIFIED

_____
PHYSICIAN SIGNATURE **FORM ATS1.5**

☐ **Negative Screening**
☐ **Screening Appropriate refer to allergy program** ☐ **Patient Declines**