**Michigan State University Olin Student Health Center Allergy/Immunization Clinic**
463 East Circle Drive
East Lansing, MI 48824-1037
517-353-9763 (Phone) 517-432-9460 (Fax)

# ALLERGY HISTORY INFORMATION SHEET

Patient Name: _____ D.O.B.: _____

Contact #: Cell: _____ Home: _____

Allergist (Physician) Name: _____ Phone: _____

Allergist Address: _____ Fax: _____

I authorize Dr. (Allergist name) _____ to release information to MSU Olin Student Health Center and authorize Olin Student Health Center to release information pertinent to allergy or injectable medication treatment to my physician.

Patient Signature: _____ Date: _____

In order for your patient to receive allergy immunotherapy at Michigan State University Olin Student Health Center the following information will need to be faxed to our Medical Records Department at 517-432-9460. ***We are unable to provide allergy immunotherapy to your patient until this form is completed and reviewed by our allergy clinic staff. Therefore, please provide this information two weeks before your patient needs their next injection. It is the patient's responsibility to ensure their insurances cover allergy injection at Olin Health Center.***

1. Reason for immunotherapy: (check all that apply) **WE DO NOT ADMINISTER VENOM SERUM**
   ☐ Allergic Rhinitis ☐ Allergic Asthma ☐ Venom Allergy ☐ Food Allergy Other: _____
2. Duration of Therapy: _____
3. If patient has asthma, are they/have they: (Check all that apply)
   ☐ On Immunotherapy ☐ On Oral Steroids
   ☐ History of Hospitalization<12 Months for Asthma ☐ History of Intubation Ever for Asthma or Anaphylaxis
4. Additional History (check all that apply): Patient Has A History of The Following:
   ☐ Taking Oral/Topical Beta Blocker ☐ Taking MAO Inhibitor ☐ Taking Tricyclic Antidepressant
   ☐ An Autoimmune Disease: ☐ HIV positive ☐ Pregnant
   ☐ Non-Asthma Pulmonary Disease/Surgery ☐ Cardiac Disease Surgery
5. Immunotherapy Reaction History (Check all that apply)
   ☐ Patient has had a reaction to serum injection requiring epinephrine treatment or anaphylaxis.
   ☐ Patient has had a reaction which required cessation of an ingredient in the serum.
   If yes to either, please describe: _____
6. Please attach dosing schedule and treatment plan for reactions, late and missed doses.

Allergist (Physician) Signature: _____ Date: _____

Print Name: _____

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Olin Student Health Center Staff Review/Sign

Physician Signature: _____ Date: _____

Nurse Signature: _____ Date: _____