University Health and Wellbeing
MICHIGAN STATE UNIVERSITY

Michigan State University Olin Clinical Health Services Allergy/Immunization Clinic
463 East Circle Drive
East Lansing, MI 48824-1037
Phone: (517) 353-9763 Fax: (517) 432-9460
www.olin.msu.edu

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 Clinical Health Services to release pertinent 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.

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: _____ Year Started 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:
   Patient has had a reaction to serum injection requiring epinephrine treatment: Yes_____ No_____
   Patient has had a reaction which required cessation of an ingredient in the serum: Yes_____ No_____
   If yes to either, please describe: _____
6. If patient has had a reaction requiring epinephrine, is it safe for the patient to receive injection at a non-allergist office? Yes_____ No_____
7. Please attach content of allergy serum (with exp. dates), dosing schedule and treatment plan for reactions, late and missed doses.

Allergist (Physician) Signature: _____ Date: _____

Print Name: _____

Olin Clinical Health Services Staff Review/Sign

Approved for Allergy Injections at University Health and Wellbeing Clinic: Yes_____ No_____

Physician Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

Patient is: New_____ Returning_____