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
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 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.***

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 Student Health Center Staff Review/Sign

Approved for Allergy Injections at Student Health Services Clinic _____

Physician Signature: _____ See EMR Date: _____

Nurse Signature: See EMR Date: _____

Patient is: New _____ Returning _____