GALVESTON
PHYSICAL MEDICINE

2724 61st Street #5
Galveston, TX 7751

ALLERGY INTAKE & CONSENT FORM

Name: _____ DOB: _____

Date of Visit: _____

Do you suffer from allergies? ☐ YES ☐ NO

If **YES**, Which Season(s): ☐ SPRING ☐ SUMMER ☐ FALL ☐ WINTER ☐ ALL YEAR

If **YES**, Which of the following symptoms do you typically have:

☐ Sneezing
☐ Itchy and/or Watery Eyes
☐ Scratchy Throat
☐ Postnasal Drip
☐ Joint Pain
☐ Itchy Dry Skin
☐ Congestion
☐ Chronic Cough
☐ Restlessness
☐ Hives
☐ Runny Nose

OTHER SYMPTOMS: _____

How long have you had these symptoms? _____ Years _____ Months

When do you typically experience them the most: ☐ MORNING ☐ NIGHT ☐ ALL DAY

Do you frequently get sinus infections, colds, the flue, or a runny nose? ☐ YES ☐ NO

Have you been diagnosed with Asthma? ☐ YES ☐ NO If **YES**, Is it Controlled? ☐ YES ☐ NO

Do you take any antihistamine medication to control these symptoms? If **YES**, please list them below and the date last take:

_____

Please list **ALL MEDICATIONS** you are currently taking, and the last date taken:

_____

Are you pregnant? ☐ YES ☐ NO

If **NO**, are you planning on becoming pregnant within the next year? ☐ YES ☐ NO

Are you HIV positive or have AIDS? ☐ YES ☐ NO

Galveston Physical Medicine
2724 61st Street #5
Galveston, TX 77551

Name: _____ DOB: _____

Date of Visit: _____

Are you taking any Beta Blocker Medications? ☐ YES ☐ NO If **YES**, which one(s)? _____

Are you taking any Antibiotic Medications? ☐ YES ☐ NO If **YES**, which one(s)? _____

Do you have any Auto Immune Diseases? ☐ YES ☐ NO If **YES**, which one(s)? _____

Have you been Allergy Tested in the last 12 months? ☐ YES ☐ NO

If **YES**, are you on immunotherapy? ☐ YES ☐ NO

Are you planning on relocating within the next 12 months? ☐ YES ☐ NO

Have you ever had a life-threatening allergic reaction that needed emergency medical attention? ☐ YES ☐ NO

Do you have any know food allergies? ☐ YES ☐ NO

If **YES**, which ones? _____

Do you have Dermatographism*? ☐ YES ☐ NO

* Dermatographism is a common benign skin condition which results in a localized hive-like reaction when the skin is scratched or when the skin is exposed to pressure or rubbing. *

CONSENTS:

By signing below, I am stating that:

- **I authorize Galveston Physical Medicine and staff to perform diagnostic allergy testing and administer immunotherapy injections that my healthcare provider considers reasonable and medically necessary.**
- **I understand that my insurance has certain guidelines for billing allergy skin tests and immunotherapy procedures and my insurance will be billed on dates of service that I am not in the provider's office.**
- **I consent to the understanding of the immunology process and would like to proceed.**
- **The opportunity has been provided for me to ask questions regarding the immunotherapy process and the potential side effects.**

I acknowledge that I have stopped ALL antihistamines 5 days prior to this testing as they may interfere with the test results.

☐ **YES** ☐ **NO**

Patient Signature: _____ **Date:** _____

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Patient Name: _____ Date: _____

Patient Number: _____ Age: _____ _____ Male _____ Female

Branson Allergy Symptom Evaluation™ (BASE)

COMPLAINTES:

Use the drop down menu and select the appropriate number 0 to 3 according to severity:

0 = absent (no symptoms evident)
1 = mild (symptoms present, but minimal awareness)
2 = moderate (tolerable)
3 = severe

Nasal Discharge (Runny Nose)	Choose ONE		Headache	Choose ONE
Nasal Obstruction (Stuffy Nose)	Choose ONE		Hives	Choose ONE
Nasal Itching	Choose ONE		Eczema	Choose ONE
Sneezing	Choose ONE		Itching Ears	Choose ONE
Watery Eyes	Choose ONE		Sinus Or Ear Infections	Choose ONE
Itchy Eyes	Choose ONE		Frequent Colds or Sore Throat	Choose ONE
Gritty Feeling (Eyes)	Choose ONE		Sensitivity To Pet Hair	Choose ONE
Cough	Choose ONE		Itchy Throat	Choose ONE
Wheezing	Choose ONE		Sinus Pressure	Choose ONE
Difficulty Breathing	Choose ONE		Sinus Pain	Choose ONE

Other symptoms causing you problems:

_____

MEDICATIONS:

How often do you take medications for your allergy symptoms? Use the drop down menu and select the appropriate number:

0 = never
1 = occasionally (several times a month or less)
2 = frequently (several times a week)
3 = daily

Antihistamines	Choose ONE		Nasal Steroids (Flonase, Nasacort)	Choose ONE
Oral Steroids	Choose ONE		Asthma Medication (Inhaler, Singulair, Advair)	Choose ONE
Eye Drops	Choose ONE			

Other Allergy-Related Medications (note the frequency):

_____

Does any medication give you complete relief of symptoms? _____

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Patient Name: _____ Date: _____

Patient Number: _____

GENERAL ALLERGY HISTORY:

How many moths of the year do you have allergies? _____ How many years? _____

In what season are they worse (Check all that apply): ☐ SPRING ☐ SUMMER ☐ FALL ☐ WINTER ☐ ALL YEAR

Have you been allergy tested before? ☐ YES ☐ NO

If YES, which type: ☐ Skin Prick/Puncture ☐ Blood Draw

Have you previously received Allergy Shots? ☐ YES ☐ NO If **YES**, when? _____

Have you previously received Allergy Drops? ☐ YES ☐ NO If **YES**, when? _____

Do you smoke or use Tobacco Products? ☐ YES ☐ NO

List any animals you have in or around the home: _____

Who else in your family has Allergies? _____

PROVIDER ONLY		
RAW SCORE: _____ / 25	**0 – 25 = MILD**	**25 – 50 = SIGNIFICANT**
SCORE: _____ (Multiply raw score by 4)	**51 – 100 = SEVERE**	**100 + = VERY SEVER**