Allergy History Form

Name: _____
Date of Birth: _____
Gender: Male / Female
Profession / Occupation: _____

Any Current Symptoms: _____

Significant Medical History
(Asthma, Bronchitis, Skin Rash, Itching, Sneezing, Watering Eyes, Rhinits etc) Please Specify
_____
_____
_____

Have you been admitted to a hospital for allergy treatment? Yes / No
If yes, please give details
_____
_____

Do you smoke? Yes / No
Do you consume alcohol? Yes / No

Are you currently on any medications? Yes / No
If yes, give details
_____
_____
_____

Do you take Vitamins / Calcium supplements? Yes / No
If yes, give details
_____
_____

Your Diet
Vegetarian □ Non Vegetarian □ Eggs □

Do you have any pets or exposure to pets (cats/dogs)? Yes / No

How did you come to know about allergy testing at Disha?
O Newspaper Advt **O** Website **O** Google Search **O** Friend **O** Family **O** Facebook **O** Doctor
O Other - Please Specify: _____

Thank you for providing this information