Patient name: _____

Allergy History Form

- Redness
- Swelling
- Skin rash, swollen lips
- Itching (ears, back of your throat)
- Burning sensation inside your mouth
- Difficulty breathing

Have you had any of the above allergy symptoms/reactions after using or eating the following?

Medication		Please give details
Antibiotics	☐No ☐Yes	
Contrast medium (CT scan dye, etc.)	☐No ☐Yes	
Pain relief medications (Loxoprofen, Aspirin, etc.)	☐No ☐Yes	
Antiseptics (alcohol swab, etc.)	☐No ☐Yes	
Other	☐No ☐Yes	

Material		Please give details
Latex	☐No ☐Yes	
Contraceptives (condoms)	☐No ☐Yes	
Rubber gloves (for kitchen, cleaning, etc.)	☐No ☐Yes	
Metals	☐No ☐Yes	
Other	☐No ☐Yes	

Food		Please give details
Fruits (kiwi, mango, banana, etc.)	☐No ☐Yes	
Nuts (peanuts, almond, etc.)	☐No ☐Yes	
Vegetables (avocado, potato, tomato, etc.)	☐No ☐Yes	
Other	☐No ☐Yes	

**** You will need to complete a different inpatient allergy form when you visit the Aiiku Hospital ****