THE ALLERGY CLINIC

CONSULT FORM

Name: _____ ☐ Male ☐ Female Date: _____

PATIENT SECTION

Major Problem:

- Skin Rashes ☐ Yes ☐ No
- Swelling ☐ Yes ☐ No
- Recurrent Infections ☐ Yes ☐ No
- Other:

_____
_____
_____
_____
_____
_____

How long have you had the problem?

_____
_____

What treatment are you on for the problem?

_____
_____
_____
_____
_____
__

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DOCTOR SECTION

General Condition:

_____

ENT: _____

Skin: _____

RS: _____

Other:

_____
_____

Impression:

_____
_____

Plan:

_____
_____
_____
_____
_____
_____