

ALLERGY ASSOCIATES & LAB., LTD.

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PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Patient Name: _____ **Acct #:** _____ **Date:** _____

Name of the medication to which you reacted: _____

How was the medication given? (Please check)

- Orally (pill, syrup, etc.)
 IV (intravenously)
 Injection (shot)
- Other, please specify: _____

When did you take this medication? _____

Why were you given this medication? _____

What type of reaction did you have? (check all that apply)

<input type="checkbox"/> Hives/Welts	Swelling <input type="checkbox"/> eyes <input type="checkbox"/> face <input type="checkbox"/> lips <input type="checkbox"/> tongue <input type="checkbox"/> other: (please specify)	Other type of reaction – Please describe
<input type="checkbox"/> Shortness of breath or trouble breathing		
<input type="checkbox"/> Wheezing		
<input type="checkbox"/> Chest tightness		
<input type="checkbox"/> Tightness in throat		
<input type="checkbox"/> Passed out		
<input type="checkbox"/> Nausea, vomiting, diarrhea, cramping		
<input type="checkbox"/> Other type of rash Please describe: _____		

How long after taking the medication did the reaction start? _____

How was the reaction treated? _____

Other information you want us to know: _____

