

ALLERGY ASSOCIATES & LAB., LTD.

1006 E. Guadalupe Rd., Tempe, AZ 85283
 2248 N. Alma School Rd., Chandler, AZ 85224
 Phone: (480) 838-4296

6553 E. Baywood Ave, Ste. 201, Mesa AZ 85206
 4901 N. 44th St., Ste. 103, Phoenix, AZ 85018
 Fax: (480) 820-1275

Dr. Suresh Anand Tempe	Dr. Miriam Anand Mesa	Dr. Dania Wierzbicki Chandler	Tera Crisalida, P.A.-C. Phoenix
---------------------------	--------------------------	----------------------------------	------------------------------------

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 spe	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: _____

