EYE CENTERS OF TENNESSEE

INITIAL ALLERGY EVALUATION

Patient Name: _____

Date of Birth: _____ Patient Phone Number: _____

Patient Number: _____ Date: _____

PATIENT HISTORY

	YES	NO
Do you have symptoms, or have you ever had symptoms, such as sneezing, watery nasal discharge, throat itching or dry mouth?	_____	_____
Do you have, or have you ever had, frequent "colds", sinus problems or chronic nasal congestion?	_____	_____
Do you have, or have you ever had, your eyes itch, water, get red or swell?	_____	_____
Are your symptoms seasonal only, or do they get worse in certain seasons?	_____	_____
Are your symptoms worse around animals?	_____	_____
Do you have, or have you ever had asthma, eczema or hives?	_____	_____
Do you have sensitivities to foods?	_____	_____
Are you taking antihistamines, sleep aids, or anti-depressant medication?	_____	_____

Please list: _____

FOR PHYSICIANS USE ONLY

ORDER FOR ALLERGY SCRATCH TESTING AND TREATMENT IF INDICATED
95004 TESTING 95165 TREATMENT
ICD – 10 DIAGNOSIS CODE: J30.1 ALLERGIC RHINITIS DUE TO POLLEN J30.5 ALLERGIC RHINITIS DUE TO FOODS

_____
PHYSICIAN SIGNATURE

FORM ADPT91918

☐ Negative Screening ☐ Screening Appropriate refer to allergy program ☐ Patient Declines