EYE CENTERS
OF TENNESSEE

INITIAL ALLERGY EVALUATION

Patient Name: _____

Date of Birth: _____ Patient Phone Number: _____

Patient Chart #: _____ Date: _____

PATIENT HISTORY

	Yes	No
Have you been tested for allergies previously?	____	____
Do you currently see an Allergist?	____	____
Do you have symptoms, or have you ever had symptoms, such as sneezing, watery nasal discharge, sinus issues, throat itching or dry mouth, dry, red, itchy eyes, or any swelling of eyes?	____	____

If yes, please describe: _____

Do your symptoms get worse seasonally?	____	____
Are your symptoms worse around animals?	____	____
Do you have, or have you ever had asthma, eczema or hives?	____	____
Are you taking antihistamines, sleep aids, or anti-depressant medication?	____	____

If yes, 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: _____

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

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