

# Allergy List

Your Full Name:

Date of Birth:

Contact Information:

Food Allergies	Environmental Allergies
<input type="checkbox"/> Milk <input type="checkbox"/> Wheat <input type="checkbox"/> Eggs <input type="checkbox"/> Soybeans <input type="checkbox"/> Fish <input type="checkbox"/> Sesame <input type="checkbox"/> Crustaceans <input type="checkbox"/> Pork <input type="checkbox"/> Tree nuts <input type="checkbox"/> Beef <input type="checkbox"/> Peanuts <input type="checkbox"/> Others:	<input type="checkbox"/> Tree pollen <input type="checkbox"/> Pet dander <input type="checkbox"/> Grass pollen <input type="checkbox"/> Smoke/smog <input type="checkbox"/> Weed pollen <input type="checkbox"/> Mice <input type="checkbox"/> Mold spores <input type="checkbox"/> Cockroaches <input type="checkbox"/> Dust <input type="checkbox"/> Others:
Medication Allergies	Insect Bite/Sting Allergies
<input type="checkbox"/> Penicillin <input type="checkbox"/> NSAIDs <input type="checkbox"/> Antibiotics <input type="checkbox"/> Chemotherapy drugs <input type="checkbox"/> Anticonvulsants <input type="checkbox"/> Insulin <input type="checkbox"/> Aspirin <input type="checkbox"/> Others: <input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Ant bite <input type="checkbox"/> Hornet sting <input type="checkbox"/> Mosquito bite <input type="checkbox"/> Spider bite <input type="checkbox"/> Bee sting <input type="checkbox"/> Cockroach bite <input type="checkbox"/> Wasp sting <input type="checkbox"/> Others: <input type="checkbox"/> Yellow jacket sting
Other Allergies	Specifics
<input type="checkbox"/> Latex <input type="checkbox"/> Metals <input type="checkbox"/> Perfumes and fragrances <input type="checkbox"/> Animal fur <input type="checkbox"/> Others:	<p>The lists contain general items. Please detail any specific allergies below:</p>

Notes: