

Allergy Skin Test

Patient information	
Name:	Date of birth:
Age:	Gender:
Contact information:	
Address:	
Date of test:	
Patient history	
I. Symptoms:	II. Medical history:
III. Medications:	IV. Known allergies
Family history of allergies: No Yes, specify:	
Test details	
I. Reason for test:	II. Special instructions:

<div>Fasting required?</div> <div>YesNo</div>			
<div>Test method used:</div> <div><div><input type="checkbox"/> Skin prick test (allergen drops are applied to skin and gently pricked or scratched)</div><div><input type="checkbox"/> Intradermal test (allergens injected under the skin)</div><div><input type="checkbox"/> Patch test (allergens applied with adhesive patches)</div></div>			
<div>Date:</div>		<div>Time:</div>	
<div>Allergies tested and reactions</div>			
<div>Allergen</div>	<div>Reaction (wheal, flare, size)</div>	<div>Severity</div>	<div>Interpretation</div>
<div>Interpretation and diagnosis</div>			
<div>Test result:</div>			
<div>Confirmed allergens:</div>		<div>Clinical diagnosis:</div>	

Results reporting

Results to be reported to:

Preferred method:

- ☐ Phone
- ☐ Email
- ☐ Mail
- ☐ In person (by appointment)

Expected result delivery time:

Additional notes

Healthcare professional information

Name:

License ID number:

Signature:

Date: