

# Allergy Skin Test

<b>Patient Information</b>	
<b>Full Name</b>	
<b>Date of Birth</b>	
<b>Gender</b>	
<b>Contact Number</b>	
<b>Address</b>	
<b>Medical History &amp; Questions</b>	
<b>Known Allergies</b>	
<b>Current Medications</b>	
<b>Previous Allergic Reactions</b>	
<b>Family History of Allergies</b>	
<b>Have you had an allergy skin test before?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, when?</b>	
<b>Any recent illness or medication changes?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Any skin conditions (eczema, psoriasis)?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tests Conducted</b>	
<b>Method Used</b>	<input type="checkbox"/> Prick Test <input type="checkbox"/> Patch Test <input type="checkbox"/> Intradermal Test

<b>Test 1 (Allergen)</b>	
<b>Test 2 (Allergen)</b>	
<b>Test 3 (Allergen)</b>	
<b>Findings</b>	
<b>Basis for Findings</b>	
<b>Test 1 Reaction</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>Test 2 Reaction</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>Test 3 Reaction</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>Interpretation</b>	
<b>Test 1 Interpretation</b>	
<b>Test 2 Interpretation</b>	
<b>Test 3 Interpretation</b>	
<b>Overall Interpretation</b>	
<b>Doctor's Signature</b>	