

Allergy and Asthma Center, 2233-F Willamette St., Eugene, OR 97405
541-485-0316

MEDICAL INFORMATION SHEET – Preliminary Penicillin Evaluation

PATIENT NAME		TODAY'S DATE	
DATE OF BIRTH		AGE	

Welcome!

You are scheduled to have a Preliminary Penicillin Evaluation today, including possible Penicillin Skin Testing. The following information will help during the evaluation and treatment of your medical condition.

THANK YOU!

BRIEFLY DESCRIBE YOUR ADVERSE REACTION TO PENICILLIN:

(Use the back of this sheet if additional space is needed).

WHEN DID THIS REACTION OCCUR?

PLEASE LIST OTHER CURRENT MEDICAL PROBLEMS FOR WHICH YOU ARE SEEING A PHYSICIAN ON A REGULAR BASIS (for example, heart disease, high blood pressure, diabetes, etc.):

MEDICAL CONDITIONS REQUIRING CURRENT TREATMENT	PRESCRIBING PHYSICIAN

PLEASE LIST *ALL CURRENT MEDICATIONS* YOU ARE TAKING:

MEDICATION:	DOSE:

Thank you for taking the time to complete this form. Please return the clipboard and all papers to the receptionist.

Signature of person complete form: _____