Allergy, Asthma & Immunology Associates, P.C.
Dr. Brett Kettelhut

Penicillin Allergy Questionnaire

Patient Name: _____ Date of Appointment: _____
Date of Birth: _____ Referring Physician: _____
Primary Care Physician: _____

1. Describe your first drug reaction (*i.e. rash, hives, swelling, trouble breathing, etc)* and when this occurred: _____
_____
_____

2. Any subsequent reactions?
When?_____
_____

3. List any other known allergies to medications/vaccines with reactions:
_____
_____
_____

4. Do you require frequent antibiotic use? _____

5. How many days since you have taken an antihistamine(s)? _____

6. Are your immunizations up to date? ☐ No ☐ Yes
   ☐ Pneumovax - *when?* _____
   ☐ Prevnar13 - *when?* _____

7. Please list any of your other diagnoses/ health problems *(i.e. high blood pressure, diabetes, heart conditions, cancer, thyroid problems, arthritis, depression, anxiety. eczema, asthma*)
   _____
   _____

8. List ALL your current medications/supplements *(include any creams, inhalers, sprays)*
   Include dose and frequency.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHARMACY: _____