UCSF Health Allergy & Immunology Clinic Pre- Injection Questionnaire

ALLERGY SHOT CINIC PRE-INJECTION CHECKLIST

First Name: _____ Last Name: _____

1. Is it possible that you have COVID-19 or been exposed to COVID-19?
   Yes ☐ No ☐ ; If YES – please call the triage nurse at 415-353-2725, opt 1, opt 3, opt 1. At this time, you are not cleared for an appointment.

2. Have you taken the pre-medication (Allegra, Zyrtec, Claritin, Singulair) your doctor has recommended?
   Yes ☐ No ☐ COMMENT: _____

3. Have you started any new medication?
   Yes ☐ No ☐ New Medication(s): _____

4. Have you had any changes in health?
   Yes ☐ No ☐ COMMENT: _____

5. Did you have any reactions after you last allergy injection?
   Yes ☐ No ☐ COMMENT: _____

6. Is it possible you could be pregnant?
   Allergy shot dosing needs to be changed during pregnancy.
   Yes ☐ No ☐ COMMENT: _____

Please score the following questions about your allergies in the right-hand column using the scale below:
5 – Never 4 – Rarely 3 – Sometimes 2 – Often 1 – Extremely Often

During the past WEEK …	SCORE
How often did you have nasal congestion?	_____
How often did you sneeze?	_____
How often did you have watery eyes?	_____
To what extent did your nasal or other allergy symptoms interfere with your sleep?	_____
How often did you AVOID any activity (e.g. gardening, exercising, visiting a house with a cat or dog) because of your nasal or other allergy symptoms?	_____
TOTAL	0

If you have asthma, please fill in this section.

Peak Flow _____ Date: _____

Please write in the number that most closely matches your symptoms.

1. In the past four weeks, how often did your asthma keep you from getting as much as you would like done at work or at home?

None of the time	(5)	
A little of the time	(4)	
Some of the time	(3)	
Most of the time	(2)	
All of the time	(1)	0

2. During the past four weeks, how often have you had shortness of breath?

Not at all	(5)	
Once or twice a week	(4)	
3 to 6 Times a week	(3)	
Once a day	(2)	
More than once a day	(1)	_____

3. During the past four weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night, or earlier than usual in the morning?

Not at all	(5)	
Once or twice	(4)	
Once a week	(3)	
2 to 3 nights a week	(2)	
4 or more nights a week	(1)	_____

4. During the past four weeks, how often have used your rescue inhaler or nebulizer medication (such as albuterol)

Not at all	(5)	
Once a week or less	(4)	
A few times a week	(3)	
1 or 2 times per day	(2)	
3 or more times per day	(1)	_____

5. How would you rate your asthma control during the past four weeks?

Completely controlled	(5)	
Well controlled	(4)	
Somewhat controlled	(3)	
Poorly controlled	(2)	
Not controlled at all	(1)	_____
TOTAL		0