

# Comprehensive Allergy History

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Patient ID: [Insert Patient ID]

## Allergy Overview

The following provides a detailed account of the patient's allergies:

### Food Allergies

- [Food Item 1] - Reaction: [Reaction Description]
- [Food Item 2] - Reaction: [Reaction Description]
- [Food Item 3] - Reaction: [Reaction Description]

### Medication Allergies

- [Medication 1] - Reaction: [Reaction Description]
- [Medication 2] - Reaction: [Reaction Description]
- [Medication 3] - Reaction: [Reaction Description]

### Environmental Allergies

- [Allergen 1] - Reaction: [Reaction Description]
- [Allergen 2] - Reaction: [Reaction Description]

## Past Reactions

[Detailed descriptions of past allergic reactions, including severity and treatment]

## Current Medications

- [Medication 1]
- [Medication 2]
- [Medication 3]

## Additional Notes

[Any additional relevant information or personal observations]

## **Prepared by**

[Healthcare Provider Name]

[Healthcare Provider Contact Information]