



## ASTHMA & ALLERGY CENTER

208 MacCorkle Ave. SE, Charleston, WV 25314  
Charleston. Parkersburg. Ripley. Beckley. Logan.  
[Asthmaweb.com](http://Asthmaweb.com)  
304.343.4300

### PENICILLIN ALLERGY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ D O B : \_\_\_\_\_ Date: \_\_\_\_\_

1. Name of the medication that caused the reaction:
2. Who diagnosed the Allergy: A doctor / Nurse / You. / Mom. . Other: \_\_\_\_\_
3. How many times have you had reaction:
4. About how many years ago (or at what age ) was the last reaction:
5. With respect to **the most serious reaction**, answer the following questions:

**5.1. Did you have:**

- Hives. Rash. Itching. Lip/Tongue/Throat / Eyelid / Other Swelling
- Shortness of Breath. Cough. Wheezing. Chest Tightness Fainting. Cold Sweat
- Nausea. Vomiting. Stomach Cramps. Other Symptoms: \_\_\_\_\_
- Visit to The ER / Urgent Care/ Dr's Office Hospital Admission.

**• Reaction started how long after taking the medication:**

- How long did the symptoms last:
- Did you have any of the following: Blistering Rash. Skin Peeling. Sores in the mouth
- Did you have any symptoms between 6 to 48 hours after the initial symptoms:

**5.2. What Treatment was given for the reaction:**

6. Have you taken any Penicillin or Cephalosporin Antibiotics since the above reaction:
7. Other Comments:

=====  
Health Care Provider Comments:

PLAN: \_\_\_\_\_ Possible Type I Allergy: Recommend Penicillin Allergy Testing and if Neg, Oral challenge with: \_\_\_\_\_  
\_\_\_\_\_ Hx suggests Type II / III / IV Reaction. TESTING NOT RECOMMENDED. Strictly AVOID PENICILLINS.

Signature & Name: \_\_\_\_\_ MD / PAC Date: \_\_\_\_\_