CABINET FOR WORKFORCE DEVELOPMENT
DEPARTMENT OF VOCATIONAL REHABILITATION
ALLERGY EVALUATION

Client's Name:_____ Age: _____

**HISTORY**

(A) Onset of Condition: _____

(B) Principal Substances to Which Allergic:_____

_____

_____

(C) Relation to Stress: _____

(D) Extrinsic _____; Intrinsic_____; Perennial_____ ; Seasonal_____

Prescribed treatment: _____

(E) Episodes - Describe duration in days, hours, or minutes despite prescribed treatment:

_____

(F) 1. Has client had intensive treatment in hospital or emergency room? ☐YES ☐NO

If Yes, give dates: _____

2. Did intensive emergency treatment include:
   a. Intravenous drug administration? ☐YES ☐NO
   b. Inhalation therapy? ☐YES ☐NO

(G) Specifically, how frequent have been the episodes of severe attacks?

_____ Per Year; _____ Per Month; _____ Per Week

(H) Have episodes resulted in missed work or school in the past year? ☐YES ☐NO

If Yes, how many days? _____

**TREATMENT**

(A) What is the ongoing prescribed treatment and by whom prescribed?_____

_____

_____

(B) Specifically, indicate treatment dates over past two years. _____

_____

(C) Clinical response to treatment: _____

_____

* *Attach continuation sheet or supplemental report as needed.*

## PHYSICAL FINDINGS

(A) Symptoms relating to Allergy: _____

_____

_____

(B) Body weight, state of nutrition, etc.: _____

_____

(C) Description of chest and lungs:

1. Prolonged expiration time: ☐YES ☐NO
2. Wheezing present between attacks: ☐YES ☐NO
3. Other evidence of chronic lung disease: _____

_____

_____

4. Results of Pulmonary Function Studies. Describe: _____

_____

_____

_____

## FUNCTIONAL CAPACITY SUMMARY

(Discuss specific mental/physical limitations pertinent to vocational planning): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

DATE OF EXAMINATION PHYSICIAN