GOAL Family Medical P.C.
Compassion. Dedication. Trust.

Skin Allergy Testing Questionnaire

Full Name _____ DOB __/__/__ Contact Phone _____

1. Do you have a history of allergies, asthma, eczema, or other related conditions?

○ Yes ○ No

2. If you answered yes to question 1, please specify the types of allergies you have (select all that apply)

○ Seasonal allergies ○ Food allergies ○ Medication allergies

○ Environmental allergies ○ Other: _____

3. Have you experienced any of the following symptoms? (select all that apply)

○ Itchy or watery eyes ○ Sneezing or a runny nose ○ Skin rashes or hives

○ Shortness of breath or chest tightness ○ Coughing or wheezing

4. Are you taking any allergy medications?

○ Yes ○ No

5. Are you interested in undergoing skin allergy testing in our office to identify your specific allergens?

○ Yes ○ No

Thank you for completing the questionnaire. Please return this form to the front desk or hand it to your healthcare provider during your appointment.

Dr. Ogadinma McGeachy
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