Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60782

Dossier : _____

Nom, prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

Installation : _____

QUESTIONNAIRE
ALLERGY CLINIC

Main reason for your visit: _____

Occupation: _____

Drug insurance: ☐ RAMQ ☐ Private **Do you smoke?** ☐ Yes ☐ No

Do you have any known health problems?

Heart: ☐ Yes ☐ No Kidneys: ☐ Yes ☐ No Skin: ☐ Yes ☐ No

Lungs: ☐ Yes ☐ No Hormones: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No Digestive: ☐ Yes ☐ No

Any other problem: _____

Do you have asthma? ☐ Yes ☐ No **Do you have eczema?** ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If yes, specify: _____

Do you have pets at home? ☐ Yes ☐ No

If yes, specify: _____

Do you have any food allergies? ☐ Yes ☐ No

If yes, specify: _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, specify: _____

Do you have seasonal allergies or year-round allergies (pollen, animals, etc.)? ☐ Yes ☐ No

If yes, specify: _____

Have you ever had an allergic reaction to an insect sting (bee, wasp, hornet)? ☐ Yes ☐ No

If yes, specify: _____

ANALYSIS AND INTERPRETATION - SECTION TO BE COMPLETED BY THE PHYSICIAN

Signature du médecin : _____ # de permis : _____ Date : aaaa/mm/jj