**Long-Term Care Resident Drug Allergy Assessment Tool**

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| **Resident**  **Name** |  | | | | | | | | | | | | **Resident**  **Date of Birth** | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Do you have any known reaction(s) to any medication(s) that you have previously taken?** | | | | | | | | | | | | | | | | | | | |
| □ NO | | | | | □ YES | | | | | | | | | □ Unsure/Unknown | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **What was the name of the medication(s) that caused your reaction(s)?** | | | | | | | | | | | | | | | | | | | |
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| **Please select the reaction that you had (Select all that apply)** | | | | | | | | | | | | | | | | | | | |
| □ Itching | | | □ Hives | | | | | | □ Nausea | | | □ Vomiting | | | | | | | □ Diarrhea |
| □ Rash/Skin Reaction | | | □ Eyelid/Lip swelling | | | | | | □ Dizziness/Drowsiness | | | □ Muscle pain/  soreness | | | | | | | □ General weakness |
| □ Wheezing/Shortness of  breath | | | □ Anaphylaxis | | | | | | □ Headache | | | □ Injection site  reaction | | | | | | | □ Fever/chills |
| ***True Hypersensitivity/Allergy Reaction*** | | | | | | | | | ***Side Effect/Adverse Effect Reaction*** | | | | | | | | | | |
| □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **How was this medication(s) taken?** | | | | | | | | | | | | | | | | | | | |
| □ By mouth | | □ On skin | | | | | | □ By injection | | | □ Inhaled | | | | | | | □ Other: \_\_\_\_\_\_\_\_ | |
|  | | | | | | | | | | | | | | | | | | | |
| **How long after taken the medication(s) did the reaction(s) start/occur?** | | | | | | | | | | | | | | | | | | | |
| □ \_\_\_ Minutes | | □ \_\_\_ Hours | | | | | | □ \_\_\_ Days | | | □ \_\_\_ Weeks | | | | | | | □ \_\_\_ Months | |
|  | | | | | | | | | | | | | | | | | | | |
| **How long ago did this reaction(s) occur?** | | | | | | | | | | | | | | | | | | | |
| □ 0 - <5 Years | | □ 5 - <10 Years | | | | | | □ 10 - <15 Years | | | □ 15 - <20 Years | | | | | | | □ ≥20 Years | |
|  | | | | | | | | | | | | | | | | | | | |
| **Did you seek/require medical attention for your reaction(s)?** | | | | | | | | | | | | | | | | | | | |
| □ NO | | | | □ YES | | |  | | | If YES, where did you seek care? | | | | | | | | | |
|  | | | | | | | | | | □ Physician Office | | | | | | □ Urgent Care | | | |
|  | | | | | | | | | | □ Emergency Department | | | | | | □ Required hospital admission | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Have you taken this medication, or one similar, since you have had the reaction(s)** | | | | | | | | | | | | | | | | | | | |
| □ NO | | | | | | □ YES, same medication(s) | | | | | | | | | □ YES, similar medication(s) | | | | |
|  | | | | | | If YES, did the same/similar reaction occur? | | | | | | | | | | | | | |
|  | | | | | | □ NO | | | | | | | | | □ YES | | | | |