**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)?** |
|  |
|  |
| **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 |