Long-Term Care Resident Drug Allergy Assessment Tool

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)

True Hypersensitivity/Allergy Reaction		Side Effect/Adverse Effect Reaction		
☐ 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

☐ 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