

CONFIDENTIAL
AGES 0 – 16 YEARS



The PENN CLINIC
NAET Allergy Testing & Treatment
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www.pennclinic.co.uk www.allergiesOK.com



(PLEASE CONTINUE ON REVERSE WHERE NECESSARY)

[BOY / GIRL] FIRST NAME _____ LAST NAME _____

ADDRESS _____

_____ POSTCODE _____

Date Of Birth ____ / ____ / _____ Contact Tel.No(s): _____

Purpose of visit:

1 Approximately when did present condition start? :

2 Any current allergies/sensitivities:

3 Any past allergies:

4 Any past allergy tests? Y/N? If Yes, when & where :

5 Allergy test results:

6 Past allergy treatments :

7 Past major illnesses or surgeries :

8 Any current prescription medications :

9 Any non-prescription medications or supplements :

10 Was patient or is patient being breast fed?

11 Any vaccinations :

12 Any additional information that might be helpful:

13 How did you hear of this therapy?

Signed

Date: / / 2007