Allergy Testing Help Sheet

Hair sample

Title: PRINT NAME: AGE:

Weight: Height:

Telephone: Occupation:

Yes / No Do you have any known allergies?

Yes / No Are you on a special diet? Vegetarian? Vegan? Other?

Yes / No Do you smoke? What sort of pets do you have?

Yes / No Are you taking Vitamins & Minerals? If so, which?

Yes / No Are you taking any medications? If so list them on the back of the help sheet.

Please clearly mark the following ONLY if you experience them regularly, i.e. at least once or twice a week.

SKIN Eczema Rashes Dermatitis Itching Psoriasis Spots Urticaria Pimples

Acne Dry skin

Mainly affecting: All of the body, Specific Areas____________________________

DIGESTION Irritable bowel Constipation Coeliac Heartburn Stomach Ache

Diarrhoea Crohn’s Colitis Indigestion Wind Other _______________

RESPIRATORY Asthma Rhinitis Itchy Eyes Catarrh Sinusitis Breathing issues

Coughing Hay fever other ______________________________

OTHER CONDITIONS REGULARLY PRESENT

Migraines   Tiredness   Stress   Headaches   M.E.   Aches & Pains in _________

Hyperactivity   Cystitis   Rheumatoid Arthritis ______________________

Water retention   Thrush   Osteo-arthritis ______________________________

OTHER HEALTH ISSUES & REASONS FOR TEST

Friendly Disclaimer: This allergy test is intended for information only. It is not a substitute for professional medical advice and is not to be used as a diagnosis. It is always wise to see your Medical Practitioner for a proper diagnosis and any beneficial medication. The Allergy Testing Services are not responsible for any adverse effects or any results that may occur from the usage of the information contained in the allergy test report or advice notes and shall not be held responsible for any claims made about this test by the clinic using our services.

I understand the above disclaimer and I agree.

Signature _______________________________

*NB. Tests sent without signature will be returned for signing.