**Supplemental Material**

**Penicillin Skin-Test Assessment Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Question** | **Response** |
| What was the name of agent which caused the event? |  |
| When did the reaction occur? |  |
| What was the nature of the event? Including symptoms and severity |  |
| What was the course of the reaction? |  |
| How long after taking the medication did it take for the symptoms to begin? |  |
| How was the reaction treated? |  |
| Did you ever experience symptoms like this before? |  |
| Can you name other antibiotics you remember taking  and tolerated? |  |
| Have you ever taken drugs similar to penicillin?  Cephalosporins such as Cephalexin (Keflex), Cefepime (Maxipime), Ceftriaxone (Rocephin)  Carbapenems such as Imipenem (Primaxin), Meropenem (Merrem), Etrapenem (Invanz) |  |

IF PATIENT IS TO BE SKIN TESTED

Do you take any medications for allergies, cold, runny nose, heartburn, and upset stomach? (i.e. Pepcid, Claritin). All anti-histamines will need to be held 24 hours prior to skin testing.