Allergy Testing Medication Sheet

Patient Name: _____

1st Appointment Date: _____ **Time:** _____ **2nd Appointment Date:** _____ **Time:** _____

IF YOU ARE ON ANY OF THE FOLLOWING MEDICATIONS CALL OUR OFFICE IMMEDIATELY. TESTING CANNOT BE PERFORMED:

Oral Beta-Blockers:

Brand Name	Generic	Brand	Generic
Betapace	Sotalol	Blocardren	Timolol
Cartrol	Carteolol	Coreg	Carvedilol
Corguard	Nadolol(BENDROFLUNETAZIDE)	Corzide	Nadol
Inderal	Propranolol	Inderide	Propranolol/HCTZ
Kerlone	Betaxolol	Levatol	Penbutolol
Lopressor	Metoprolol	Normodyne	Labetalol
Sectral	Acebutolol	Tenoretic	Atenolol/HCTZ
Tenormin	Atenolol	Timolide	Timolol/HCTZ
Toprol	Metroprolol	Trandate	Labetalol
Visken	Pindolol	Zebeta	Bisoprolol
Ziac	Bisoprolol/HCTZ		

Oral Beta-Blockers:

Eye Drops Containing Beta Blockers:

Brand	Generic	Brand	Generic
Betagan	Levolbunolol	AK Beta	Levobunolol
Betopic	Betaxolol	Optipranolol	Metipranolol
Ocupress	Carteolol	Timoptic	Timolol

IV: Beta Blocker
Brevibloc (esmolol)

Please stop the following medications 3 days prior to testing

Antihistamines:

Brand Name	Generic	Brand Name	Generic
Allegra	Phenergan	Atarax	Rynatan
Atrohist	Rynatuss	Benadryl	Semprex
Bromfed	Sinulin	Claritin	Tavist
Codimal DH SyrupTrinalin	Dimetane CoughSyrup	Tussionex	Patanase
Dura-Vent	Tylenol Allergy	Extendryl	Tylenol Cold
Hycomine Compound	Tylenol Flu	Kronofed	Tylenol PM
Nolamine	Vistaril	Nolahist	Zyrtec
Periactin	(none)		Xyzal

Antihistamines - Generic: Astelin/Asteroo

Acivastine	Astemizole	Azatadine	Azelastine	Brompheniramine Cetirizine
Chlorpheniramine	Cyproheptadine	Diphehydramine	Fexofenadine	Hydroxyzine
Loratidine	Methscopolamine	Phenidamine	Promethazine	Pyrilamine

The following Antidepressants will affect test results. Call the prescribing physician if you can discontinue these medications for 3 days prior to your testing.

Brand Name	Generic	Brand Name	Generic
Elavil	Amitriptyline	Asendin	Amoxapine
Anafranil	Clomipramine	Norpramin	Desipramine
Sinequan	Doxepin	Tofranil	Limipramine
Pamelor	Notriptyline	Vivactil	Protriptyline
Vivactil	Protriptyline	Surmontil	Trimipramine
Maprotiline		Remeron	Mirtazapine

Allergy Instruction Sheet

Appointment: If you need to cancel your appointment please call 48 hours prior to your Scheduled visit.

Eating: Do not change your diet before allergy testing. Please eat Breakfast if you are scheduled for an a.m. appointment, or lunch if you are scheduled for a p.m. appointment.

Attire: Please make sure to wear a short sleeve short for both sessions

Time: The first session will take about 20 minutes. The second session may take up to 30 minutes.

Authorization for Testing

I _____understand that I will be undergoing Prick and Intradermal dilutional testing. The type of testing has been reviewed with me and I understand the purpose and the need. I understand no testing is done without risk. Allergic reactions from injections may occur.

Allergy testing is a method to test patients by administering specific allergens that are airborne in the area in which you live. Pollens, molds, dust, animal dander.

Reactions: During the time you are being tested if you experience any of the following symptoms please inform the tester immediately.

- Tingling or itching sensation
- Sneezing
- Sweating/Body Temperature Change
- Sensation of a lump in the throat
- Tightness in the chest
- Wheezing
- Itching on the roof of the mouth or tongue

I have read and understand the need for testing and consent to testing.

Patient Name: _____ Date: _____

Child's Name: _____ Date: _____

Parent's Signature: _____ Date: _____

Major Reason for Visit/Testing:

☐ Hay fever/ Sinus ☐ Eye Problems ☐ Asthma/ Chronic Cough ☐ Hives/Swelling ☐ Eczema or other Rash ☐ Headaches
☐ Insect Reaction ☐ Drug Reaction ☐ Intestinal Problem ☐ Food Allergy ☐ Recurrent Infections
☐ Other: _____

Do you have any of these symptoms? (Please check)

Eye Symptoms: ☐ None ☐ Itching ☐ Watery ☐ redness ☐ swelling ☐ crusting ☐ dryness ☐ burning ☐ circles ☐ blurring ☐ Puffy

Ear Symptoms: ☐ None ☐ itching ☐ popping ☐ congested ☐ frequent infections ☐ fluid ☐ hearing loss ☐ earaches ☐ dizziness ☐ Pressure

Nasal Symptoms: ☐ None ☐ sneezing ☐ itching ☐ sniffles ☐ water discharge ☐ cloudy discharge ☐ congestion ☐ frequent nosebleeds ☐ loss of sense of smell ☐ loss of sense of taste ☐ polyps ☐ frequent sinus infections ☐ nasal dryness ☐ snoring

Mouth & Throat Symptoms: ☐ None ☐ Frequent sore throats ☐ hoarseness ☐ itchy throat ☐ difficulty swallowing ☐ mouth breathing ☐ frequent strep throat ☐ frequent tonsillitis ☐ Post Nasal drip ☐ Itching of roof of mouth

Headaches: ☐ None ☐ infrequent ☐ occasional ☐ Frequent – with sinus symptoms ☐ sharp ☐ dull ☐ pounding. In what area of the head: ☐ facial ☐ forehead ☐ temples ☐ back of head.

Chest Symptoms: ☐ None ☐ chronic cough ☐ chest tightness/congestion ☐ wheezing ☐ shortness of breath
☐ Wheeze / cough after exercise ☐ sputum production ☐ chest pain or soreness

Stomach/Intestinal Symptoms: ☐ None ☐ nausea and vomiting ☐ bloating ☐ loss of appetite ☐ abdominal pain or cramping
☐ Diarrhea frequently ☐ constipation frequently ☐ pain 0difficulty swallowing ☐ heartburn/indigestion

Skin Symptoms: ☐ None ☐ Dry Skin ☐ Hives ☐ Swelling ☐ Itchy Skin ☐ Eczema ☐ poison ivy/oak ☐ sensitivity to metals
☐ Sensitivity to chemicals ☐ Sensitivity to cosmetics ☐ Athlete's foot ☐ Blisters

Women of childbearing age: Are you pregnant, trying to conceive, or nursing a baby? ☐ Yes ☐ No

Do any of the following seem to trigger (or cause) symptoms or bother you? (Please check)

☐ Grass	☐ Cats	☐ Cosmetics*	☐ Drafts	☐ Nervousness	☐ Mowing Lawn/Yard Work
☐ Hay	☐ Dogs	☐ Aerosol Sprays*	☐ House Dust	☐ Cold Air	☐ Vacuuming/House Dust
☐ Horses	☐ Perfumes*	☐ Mold & Mildew	☐ Smoke	☐ Humidity	☐ Pollen
☐ Basements	☐ Insecticides*	☐ Pollution	☐ Weather Changes	☐ Leaves	☐ Alcoholic Beverages
☐ Odors	☐ Exercise	☐ Latex	☐ Clothing*	☐ Wet Weather	☐ Dry Weather
☐ Damp Areas	☐ Windy Day	☐ Hot Day	☐ Food*	☐ Chemical Fumes	
☐ Cleaning Agents		☐ Newspaper	☐ Beer	☐ Wine	☐ Stress

*If you checked any box with an asterisk please answer the following questions:

Circle which ones affect your problem:

Irritants: ☐ Cleanser ☐ Detergent ☐ cooking odor ☐ Powder ☐ mothballs ☐ motor fumes ☐ paint lacquer ☐ wax glue ☐ Insect spray ☐ fertilizers ☐ ammonia ☐ room deodorants ☐ Clorox

Toiletries: ☐ Soap ☐ Shampoo ☐ shaving cream ☐ after-shave ☐ spray deodorants ☐ hair spray ☐ hair tonic ☐ hair dye ☐ Hand Cream ☐ Make up ☐ Toothpaste ☐ Denture Cream ☐ Mouthwash ☐ Nail Polish

Foods: ☐ Milk ☐ Cheese ☐ Eggs ☐ Fish ☐ Shellfish ☐ Nuts ☐ Chocolate ☐ Juices ☐ Spices ☐ vegetables ☐ Strawberries ☐ Wheat Products

Clothing: ☐ Wool ☐ Silk ☐ Sweater ☐ Coat ☐ Shoes ☐ dry-cleaned Clothes ☐ Starch Clothes

Other Animals specify: ☐ Rat ☐ Mice ☐ Guinea Pig ☐ Parakeet ☐ Other: _____

How long have you had your symptoms? _____ Are they getting worse? ☐ Yes ☐ No

When are your symptoms worse? ☐ Year Round
☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Have you ever been Allergy Tested? ☐ Yes ☐ No When: _____

Have you had allergy injections? ☐ Yes ☐ No When: _____

Do your symptoms disturb your sleep ☐ No ☐ occasionally ☐ frequently?

Occupation: _____ any harmful exposure at work or school: _____

Environmental Survey:

How long have you lived in your house/apartment _____ ☐ House ☐ Apt/Duplex ☐ Condo/Townhouse?
How old is your home? _____ Do you live in ☐ City ☐ Suburb ☐ Rural area
Do you have a basement ☐ yes 0☐ no Are you on a concrete Slab ☐ yes ☐ no?
Type of Heating System ☐ Hot Air ☐ Radiator ☐ Electric ☐ Hot Water – Baseboard
Do you have ☐ Wood/coal stove ☐Humidifier ☐ Dehumidifier ☐ Air Cleaner
Pets ☐ None Cat #_____ Indoor only Indoor/Outdoor Dogs #_____ Birds #____ Other _____ #____
Are there any tobacco smokers in your home ☐ yes ☐ no
Is your bedroom in the basement? ☐Yes ☐ no
DO you have allergy proof encasing for pillows or mattress? ☐ Yes ☐ no
What type of pillows do you have? ☐ Feather ☐ Poly fill ☐ other: _____
What type of comforter do you have? ☐ Feather/Down ☐ Polyfill ☐ Other: _____
What type of floor covering do you have in your BEDROOM? ☐ Wall to wall carpet ☐ area rug ☐ animal skin ☐ bare floor
How old is your mattress? _____ What is in your mattress: _____Cotton _____Horse Hair _____ other
Do you have Air conditioning? ☐ Yes ☐ Central ☐ Units ☐ No
Do you have problem with ___Roaches ____Mice ____ Rats? ☐ NO
Do you have water leaks ☐ Yes ☐ No or Mold Concentration ☐ Yes ☐ No

Family History:
Who in your family has had?
Asthma: _____ Eczema: _____ Seasonal year around Allergies: _____
Other Allergies: (Drugs/Bee Stings/Food): _____ Sinus Problems: _____

List any Food allergies and reactions experienced: _____
_____
_____

List any Drug Allergies and reactions experienced: Penicillin, aspirin, sulfa, latex: _____
_____
_____

List All Medications you are currently taking or have taken in the last 3 months: (☐ None
(Include Prescription and over-the-counter)

Medicine	Currently Taken	Discontinued when

Do you smoke? 0 Yes 0 No Have you smoked in the past 0 Yes 0 No When stopped: _____ how long did you smoke ___

Food Allergy Questionnaire

Have you:

For as long as you remember had – headaches, skin rashes, constant colds, viruses, fleeting pains, bloating, sleep problems, stomach upsets? ☐ Yes ☐ No

Tried to lose weight and never succeeded and if you have lost weight have you put it on again? ☐ Yes ☐ No

Ever made a major change to your diet and after an initial high, felt worse? ☐ Yes ☐ No

Had bouts of anxiety, nervousness or depression for no apparent reason? ☐ Yes ☐ No

Do you feel tired after a full night's sleep? ☐ Yes ☐ No

Are there any foods or beverages that you crave or eat frequently? ☐ Yes ☐ No If so, please list:

Are there any foods or beverages that you dislike? ☐ Yes ☐ No If so, please list:

Are you wakened between the hours of 1:00 am – 5:00 am with the following symptoms, headache, dizziness, stomach cramps, and bloating, dry cough? ☐ Yes ☐ No

Do you ever have itching of the skin, plate or rough of your mouth or skin rash? ☐ Yes ☐ No 1 frequently 2 occasionally 3 rarely

Do you ever frequently notice swelling of your ankles, feet, hands, or face? ☐ Yes ☐ No

Do you experience marked fatigue two to three hours after meals? ☐ Yes ☐ No

Do you eat snacks frequently between meals? ☐ Yes ☐ No

Do you have excessive chilling when a sudden change in temperature occurs? ☐ Yes ☐ No

Do you have frequent headaches or "migraine"? ☐ Yes ☐ No

Do you experience belching, or abdominal distention, bloating, cramping following meals? ☐ Yes ☐ No

Have you noticed numbness of the face, arms, or legs at period intervals for no apparent cause? ☐ Yes ☐ No

Do you have drowsiness, headache or bloating following the ingestion of a cocktail, glass of beer or glass of wine? ☐ Yes ☐ No

Do you have alternating constipation and diarrhea? ☐Yes ☐ No

Do you have headaches in the back of your head? ☐ Yes ☐ No

Do you ever experience repeated symptoms on awaking in the morning, such as headache? ☐ Yes ☐ No
Can you make the headache go away by eating or drinking food such as coffee or coke? What food(s) helps to improve the symptoms? Write in the foods:

Does this happen 1 – Frequently 2 – Occasionally

Do you have recurring fungal infections? (Vaginitis, athlete's foot, jock itch, or ring worm0? ☐ Yes ☐ No