PREPARATION FOR ALLERGY TESTING

*** Please read this information at least one week before your upcoming visit.

In order to obtain valid and useful skin testing results, you will need to stop the use of certain medications for a specific amount of time before your appointment.

- **All over-the-counter (OTC) and prescription antihistamines**: Benadryl (diphenhydramine), Allegra (fexofenadine), Zyrtec (cetirizine), Claritin (loratadine), Alavert (loratadine), Xyzal (levocetirizine), Clarinex (desloratadine), and Atarax (hydroxyzine) need to be stopped 5 days before your appointment.

- **Antihistamine nose sprays**: Astelin (azelastine), Astepro (azelastine), Patanase (olopatadine), and Dymista (Fluticasone/Azelastine) need to be stopped 5 days before your appointment.

- **Allergy eye drops**: Pataday/Patanol/Pazeo (olopatadine) and OTC Allergy eye drops (Zaditor, Alaway, OphconA, etc.) need to be stopped 5 days before your appointment.

- Please keep in mind that many OTC cough and cold medications contain antihistamines including Tylenol PM, Tylenol Cold and Cough, and Tylenol Flu. These should also be stopped 5 days before your appointment.

- **Nasal steroid sprays** including Flonase/Flonase Sensimist/Clarispray (fluticasone), Nasacort (triamcinolone), Rhinocort (budesonide), Nasonex (mometasone), Qnasl (Beclamethasone), and Zetonna/Omnaris (Ciclesonide) do not need to be stopped before your appointment.

- **Singulair (Montelukast)** does not need to be stopped before your appointment with us.

- **Inhalers for asthma, cough, or wheezing** do not interfere with skin testing and should not be stopped before your appointment.

- There are not restrictions on diet; no fasting is needed for allergy testing.

- You can expect your first visit to last from 1-2 hours. For pediatric patients, please ensure that the family member who is bringing the patient can provide an accurate and detailed history. Patients under the age of 18 years must be accompanied by a parent or guardian.

- Please fill out the attached Allergy/Immunology New Patient information form and bring it with you as this will save you time during your appointment.

- Please bring any currently prescribed allergy, asthma, or eczema medications with you.

If you are unable to stop any of the above medications as requested or have any other questions please call us in advance at 704-355-9659 or 704-667-3960.
ALLERGY and IMMUNOLOGY NEW PATIENT FORM

Patient Name: ____________________________________________________ Age ____________________

Emergency Contact Information:
Name________________________________________________________ Relationship____________________
Emergency contact number____________________________________

Physicians (Please list name and address of each practitioner):
Referring Physician___________________________________________________________

Primary Physician if different from above____________________________________

Medical History:
Main reason for the allergy or immunology evaluation?__________________________

How long has the problem been occurring?

How severe are the symptoms when you or your child’s allergies are active?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>No problem</th>
<th>Minimal problem</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Irritability</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Dizziness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Sore throat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Sinus headache/pressure</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Sneezing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Nasal itching</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Nasal blockage</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Nasal green/yellow mucus</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Clear watery mucus</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Drip down the throat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Loss of sense of smell</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Snoring</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Earache</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Eye itching</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Eye redness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Eye watering</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Eye burning</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Coughing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Wheezing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Chest tightness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Chest pain</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Phlegm</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
When do allergy symptoms occur?
Seasonal (Fall Winter Spring Summer) Year round

What makes symptoms worse?
Animals Dogs Cats Dust Home Indoors Workplace
Outdoors Trees Cut grass Weeds Mold
Rain Wind Weather Change Changes in Barometric Pressure
Emotions Exercise Infection Irritants Chemicals Perfumes Smoke

In the past 12 months, how many times did you or your child 
miss work or school due to allergies, asthma or sinusitis? __________________________
go to the emergency room due to allergy, asthma or sinusitis? __________________________
get admitted to a hospital for allergies, asthma or sinusitis? __________________________
use antibiotics for sinus, chest or ear infections? __________________________
require oral steroids asthma or sinus treatment? __________________________

Previous allergy testing: □ No □ Yes, year ______ by Dr. __________________________
located __________________________

Previous allergy shots: □ No □ Yes, from __________________________ to __________________________

Do you have Asthma? □ No □ Not certain □ Yes
If “Yes,” last lung function test was performed in year of __________

Reactions to foods if any, please list __________________________

Reaction to insect bites, if any please describe __________________________

Latex exposure regularly? □ No □ Yes If yes, what and where? __________________________

Any symptoms with latex exposure? □ No □ Yes
Rash, Itching, Hives, Sneeze, Itchy nose, Runny nose, Congestion, Eye symptoms, Cough, Wheeze,
Chest tightness, Shortness of breath, Other: __________________________

Please list all medications that have been tried specifically for allergies (including prescription or over-
the-counter pills, nasal sprays, inhalers, and eye drops): __________________________


Previous or Current Medical Illnesses and Surgeries:

Is there a history of sinus surgery? □ No □ Yes If yes, date and reason: __________________________
Social History (Adults Only):

Occupation: ____________________________________________

Are you concerned about any occupational allergy exposure? □ No □ Yes
If yes, please describe: ______________________________________

Present marital status: □ Single □ Partnered □ Married □ Divorced □ Widowed

Do you use tobacco in any way? □ No □ Yes
If yes, frequency? ______________________________________

Have you smoked in the past? □ No □ Yes
If yes, when did you stop? ______________________________________

Social History (Children Only):

Is your child in a daycare or preschool? □ No □ Yes

Is your child exposed to tobacco smoke? □ No □ Yes

Who lives at home with your child? ______________________________________

Environmental History:

Pets? □ No □ Yes, please list ______________________________________

Floor coverings in your home: □ carpet □ wood □ tile □ other hard surface

Mold or known water damage in home? □ No □ Yes

Free standing humidifier in your home? □ No □ Yes

How often are the air filters on the return vents changed? ______________________________________

Family History:

Nasal allergies: □ No □ Yes, if so, relation to patient ______________________________________

Asthma: □ No □ Yes, if so, relation to patient ______________________________________

Eczema: □ No □ Yes, if so, relation to patient ______________________________________

Food allergies: □ No □ Yes, if so, relation to patient ______________________________________

Recurrent infections: □ No □ Yes, if so, relation to patient ______________________________________

Medications:

Please list all medications you are currently taking (prescribed, OTC and supplements):

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>daily</th>
<th>or</th>
<th>as needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Any medication allergic reactions? □ No □ Yes

Please describe: ______________________________________
Review of Systems (Please check any symptoms that are ongoing):

Constitutional
☐ recurrent fevers ☐ unexplained weight loss ☐ unexplained weight gain
☐ weakness/fatigue ☐ night sweats
☐ Other

Head
☐ headaches ☐ dizziness ☐ sinusitis
☐ Other

Eyes
☐ redness ☐ itching ☐ irritation ☐ dry eyes ☐ eyelid swelling
☐ Other

Ears/Nose/Throat/Mouth
☐ decreased hearing ☐ sneezing ☐ nasal drainage ☐ nasal congestion ☐ itching
☐ sinusitis ☐ nosebleeds ☐ sore throat ☐ snoring ☐ mouth sores
☐ Other

Respiratory
☐ shortness of breath ☐ chest tightness ☐ chronic cough ☐ wheezing ☐ shortness of breath with exertion only
☐ coughing up blood ☐ Other

Cardiovascular
☐ chest pain ☐ high blood pressure ☐ irregular heartbeats ☐ palpitations
☐ Other

Gastrointestinal
☐ heartburn / GERD ☐ lactose intolerance ☐ diarrhea ☐ vomiting ☐ abdominal pain
☐ Other

Endocrine
☐ diabetes ☐ heat / cold intolerance ☐ Other

Blood/Lymphatic
☐ swollen lymph nodes ☐ easy bruising/bleeding ☐ Other

Musculoskeletal
☐ joint pain ☐ muscle aches ☐ weakness ☐ Other

Skin
☐ Rashes ☐ Hives or swelling ☐ Dry skin ☐ Other

Psychiatric
☐ depression ☐ anxiety ☐ mood swings ☐ Other

☐ Yes, Antihistamine medications have been withheld for the past ______ days.
☐ No, Antihistamine medications have not been withheld for the past seven days.