Atrium Health Allergy, Asthma, Immunology New Patient Form

Please read & complete this information prior to your upcoming visit

Please stop the use of the medications listed below at least 5 days before your appointment.

This will help us obtain valid and useful skin testing results and prevent rescheduling of your allergy skin testing.

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).

Antihistamine nose sprays: Astelin (azelastine), Astepro (azelastine), Patanase (olopatadine), and Dymista (Fluticasone/Azelastine).

Allergy eye drops: Pataday/Patanol/Pazeo (olopatadine) and OTC Allergy eye drops (Zaditor, Alaway, OphconA, etc.)

OTC cough and cold medications that contain antihistamines including Tylenol PM, Tylenol Cold and Cough, Nyquil, Delsym, and Tylenol Flu to name a few. Please read labels prior to taking them.

Do not discontinue the following medications:

- ✓ **Nasal steroid sprays** including Flonase/Flonase Sensimist/Clarispray (fluticasone), Nasacort (triamcinolone), Rhinocort (budesonide),Nasonex (mometasone), Qnasl (Beclamethasone), and Zetonna/Omnaris (Ciclesonide)
- ✓ **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.

Additional Information

- There are no 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.

We look forward to meeting you!

If you are unable to stop any of the above medications or a have any other questions, please call us in advance at 704-355-9659 or 704-667-3960.

SouthPark Office
4525 Cameron Valley Parkway
Suite #2100
Charlotte, NC 28211

Pineville Office
10650 Park Road
Suite #330
Charlotte, NC 28210

Environmental Allergies/Asthma/Cough/Infections

Patient Name:_____ Age_____

Emergency Contact Information**:** Name_____

Relationship_____ Emergency contact# _____

Name of Referring Physician (incl. address)_____

_____

Name of Primary Physician if different from above_____

Medical History:

Main reason for today's evaluation?_____

_____

How long has the problem been occurring?_____

How severe are the following symptoms, if present?

General	Mild	Moderate	Severe	None
Fatigue				
Trouble sleeping				
Irritability				
Dizziness				
Headache				
Frequent infections				
Snoring				
Recurrent Fever				
Weight loss				

Head	Mild	Moderate	Severe	None
Sore throat				
Sinus pressure				
Sneezing				
Nasal itching				
Nasal blockage				
Nasal mucus				
Drip down the throat				
Loss of sense of smell				
Earache or fullness				
Eye itching				
Eye redness				
Eye watering				
Eye burning				

Respiratory	Mild	Moderate	Severe	None
Shortness of breath				
Coughing				
Wheezing				
Chest tightness				
Chest pain				
Phlegm				

Gastrointestinal	Mild	Moderate	Severe	None
Abdominal pain				
Diarrhea				
Nausea				
Vomiting				
Constipation				
Heartburn				
Bloating				

Musculoskeletal	Mild	Moderate	Severe	None
Joint pain				
Joint Swelling				

Skin	Mild	Moderate	Severe	None
Rashes				
Hives				
Discoloration				

When do your symptoms occur? All year, Fall, Winter, Spring, Summer, After eating
Other: _____

How long do symptoms last? _____ min/hr/days/weeks **What makes symptoms better?** _____

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 Certain Foods

In the past 12 months, how many times did your symptoms cause you to:

miss work/school? _____ use antibiotics? _____

go to the emergency room/urgent care? _____ require oral steroids? _____

get admitted to a hospital? _____

Reactions to foods, please list foods_____

_____

Reaction to bites, please describe insect and reaction: _____

Reactions to Latex? Do you have regular exposures: ❑ No ❑ Yes If yes, what and where? _____

Symptoms with latex exposure? ❑ No ❑ Yes _____

Reactions to medications? please list: _____

What symptoms did you experience**?** _____

Previous allergy testing?: ❑ No ❑ Yes, year _____ by Dr. _____

located _____

Previous allergy shots?: ❑ No ❑ Yes, from _____ to _____

Do you have Asthma? ❑ No ❑ Not certain ❑ Yes, last lung function test was performed in year of _____

Do you have eczema? ❑ No ❑ Not certain

Do you have a history of sinus surgery? ❑ No ❑ Yes**,** date: _____

Please list all medications that have been tried for your symptoms (including prescription & over-the-counter):_____

_____

_____

_____

Antihistamine medications have been withheld for the past 5 days: ❑ Yes ❑ No

Previous or Current Medical Illnesses and Surgeries: _____

_____

_____

Do you take a Beta-Blocker or Ace Inhibitor for elevated blood pressure: ❑ Yes ❑ No ❑ Not sure

Social History (Adults Only):

Occupation: _____

Are you concerned about occupational allergy exposure? ❑ No ❑ Yes, please describe:_____

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

Do you currently use tobacco or vaping products ? ❑ No ❑ Yes, please list frequency & type: _____

Have you smoked/vaped in the past? ❑ No ❑ Yes, when did you stop? _____

Hobbies_____

Exercise/Sports _____

Profession/job duties_____

Exposure to chemicals/machinery/industrial/construction sites at work? Yes / No

Do you wear sunscreen daily**?** Yes / No / Only when outdoors for long period of time

Do you tan, using tanning booth or spray tan? Yes / No

Are you pregnant or planning a pregnancy? Yes / No

Recent travel out of the country: _____ Recent Vaccinations: _____

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_____

Please fill below only if you have difficulty with dermatitis/rash:

Current areas affected: Scalp face eyelids top of hand palms fingertips between fingers arms chest back genitals legs feet

Symptoms: itching pain peeling burning cracking redness

When did you first notice the problem? _____

How many times in a month does it happen? _____

Any triggers: _____

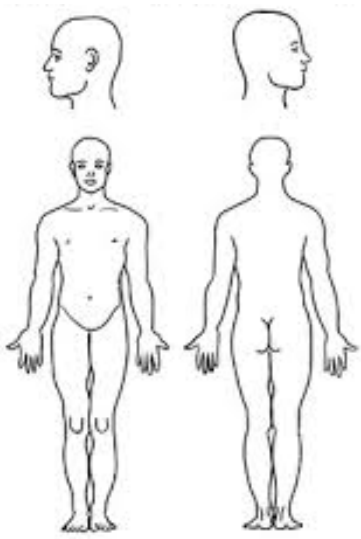
Does it go away / get better: No Yes, what makes it better _____

Treatments tried: _____

Do symptoms improve during weekends/holidays vacations No Yes

Any loss of work due to these symptoms: No Yes, list dates: _____

List vitamins, herbal, diet/energy/immune, topical supplements currently taking:



_____

Current cosmetics/ products

Circle any of the products that use you and list brand for each

Face cream	Detergent	Perfume
Foundation	Blush/Bronzer/Contour	Hair coloring/processing
Body cream	Fabric softener	Shampoo
Concealer	Lipstick/lip gloss	Nail polish
Eye cream	Dryer sheets	Conditioner
Powder	Hair gel	Aromatherapy massage oils

Healthcare and personal devices (circle <u>personal</u> history)

crowns / fillings/ bridges /amalgam braces /aligners gold implants tattoos / permanent makeup

piercings stents pacemaker defibrillator artificial joints within the past 2 years

artificial heart valve eye/sun glasses contact lenses orthotics

History of biopsies (where/when): _____

Allergy to adhesive/topical antibiotic ointments/ lidocaine/epinephrine: Yes / No

Describe: _____