Carolinas HealthCare System

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 a 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?

	No problem	*Minimal problem*	*Mild*	*Moderate*	*Severe*	*Very severe*
Fatigue	*0*	*1*	*2*	*3*	*4*	*5*
Trouble sleeping	*0*	*1*	*2*	*3*	*4*	*5*
Irritability	*0*	*1*	*2*	*3*	*4*	*5*
Dizziness	*0*	*1*	*2*	*3*	*4*	*5*
Sore throat	*0*	*1*	*2*	*3*	*4*	*5*
Sinus headache/pressure	*0*	*1*	*2*	*3*	*4*	*5*
Sneezing	*0*	*1*	*2*	*3*	*4*	*5*
Nasal itching	*0*	*1*	*2*	*3*	*4*	*5*
Nasal blockage	*0*	*1*	*2*	*3*	*4*	*5*
Nasal green/yellow mucus	*0*	*1*	*2*	*3*	*4*	*5*
Clear watery mucus	*0*	*1*	*2*	*3*	*4*	*5*
Drip down the throat	*0*	*1*	*2*	*3*	*4*	*5*
Loss of sense of smell	*0*	*1*	*2*	*3*	*4*	*5*
Snoring	*0*	*1*	*2*	*3*	*4*	*5*
Earache	*0*	*1*	*2*	*3*	*4*	*5*
Eye itching	*0*	*1*	*2*	*3*	*4*	*5*
Eye redness	*0*	*1*	*2*	*3*	*4*	*5*
Eye watering	*0*	*1*	*2*	*3*	*4*	*5*
Eye burning	*0*	*1*	*2*	*3*	*4*	*5*
Shortness of breath	*0*	*1*	*2*	*3*	*4*	*5*
Coughing	*0*	*1*	*2*	*3*	*4*	*5*
Wheezing	*0*	*1*	*2*	*3*	*4*	*5*
Chest tightness	*0*	*1*	*2*	*3*	*4*	*5*
Chest pain	*0*	*1*	*2*	*3*	*4*	*5*
Phlegm	*0*	*1*	*2*	*3*	*4*	*5*

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):

Name	*Dose*	*daily*	*or*	*as needed*
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐

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.**