

You have been scheduled for allergy testing. In an effort to know as much as we can about you to assist with your assessment, please print and complete Pages 3 and 4 and bring them to your appointment. Please read ALL the forms thoroughly to be aware of all pre-testing requirements. Thank you!

A \$100 fee will be assessed if you no-show, cancel, or reschedule with less than 24 hours notice.

This packet contains a list of medications that interfere with skin testing. If you are taking **ANY** of the listed medications, please call the office to speak with our allergy department.

You must be off all antihistamines for the recommended amount of time prior to testing. (see list)

PER OUR POLICY: If you are taking a medication in the beta-blocker class, we will need written consent from the prescribing physician stating that you are able to hold your medication for 48 hours prior to testing. NOTE: Never stop one of these medications without first discussing with the prescribing physician.

Prior to your skin testing appointment please let our allergy department know:

- If you have: fever, wheezing, shortness of breath, chest cold, or are using rescue inhaler more than two times a week. **(Skin testing will be rescheduled if your asthma is not well controlled.)**
- If you are pregnant.
- If you are taking any beta blockers or antidepressants. Beta blockers may worsen allergic reactions and may prevent adrenalin (epinephrine) from reversing systemic reaction.
- If you have a history of fainting.

All medications for Asthma, including inhalers, should be taken unless otherwise directed by your physician. If you are taking expectorants/decongestants as well as nasal steroids, you may continue.

- PLEASE DO NOT SKIP MEALS BEFORE THE TEST
- WEAR A LOOSE SHORT SLEEVE SHIRT OR SLEEVELESS TOP
- AVOID SUNBURN AT LEAST ONE WEEK BEFORE THE TEST
- PLEASE DO NOT BRING SMALL CHILDREN
- THE TEST TAKES APPROXIMATELY 1.5 HOURS
- PLEASE BE ON TIME. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE CONTACT THE ALLERGY DEPARTMENT WITH AT LEAST 24 HOURS NOTICE TO AVOID CANCELLATION FEES.

Thank you.
The Allergy Department at ENT Associates

HOLD THE FOLLOWING ANTIHISTAMINES (ALLERGY MEDICATION) 3 DAYS PRIOR TO TEST VISIT.

Alrex (eye)	Benadryl (Diphenhydramine)	Patanase
Astepro	Dymista	Pazeo (eye)
Astelin	Olopatadine (eye)	Ryaltris
Azelastine	Pataday (eye)	Zatidor (eye)

HOLD THE FOLLOWING ANTIHISTAMINES (ALLERGY MEDICATION) 7 DAYS PROR TO TEST VISIT.

Alavert (Loratadine)	Chlor-Trimeton (Chlorpheniramine)	Phenergan (Promethazine)
Allegra (Fexofenadine)	Claritin (Loratadine)	Xyzal (Levocetirizine)
Atarax/Rezine (Hydroxyzine)	Periactin (Cyproheptadine)	Zyrtec (Cetirizine)

HOLD SLEEP, SINUS, COUGH AND COLD MEDICATION 3 DAYS PRIOR TO TEST VISIT.

Ambien (Zolpidem)	Meclizine	Melatonin	Tylenol PM	Vit C 500mg
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TRICYCLIC ANTIDEPRESSANTS & BENZODIAZEPINES HOLD 7 DAYS PRIOR TO TESTING VISIT.

Alprazolam (Xanax)	Desipramine (Norpramin)	Midazolam (Versed)
Amitriptyline (Elavil)	Diazepam (Valium)	Nortriptyline (Pamelor)
Amoxapine (Asendin)	Doxepin (Sinequan)	Protriptyline (Vivactil)
Clomipramine (Anafranil)	Imipramine (Tofranil)	Restoril (Temazepam)
Clonazepam (Klonopin)	Lorazepam (Ativan)	Trimipramine (Surmontil)

ATYPICAL ANTIDEPRESSANTS/SEDATIVES HOLD 5-7 DAYS PRIOR TO TESTING VISIT.

Bupropion (Wellbutrin)	Mirtazapine (Remeron)	Trazodone (Olepro)
Maprotiline (Ludiomil, Deprilept, Psymion)	Quetiapine (Seroquel)	

Note: Please check with prescribing physician before holding antidepressants.

HOLD THE FOLLOWING ANTI-ULCER MEDICATIONS FOR 1 DAY BEFORE THE TEST:

Axid (Nizatidine)	Pepcid (Famotidine)	Tagamet (Cimetidine)	Zantac (Ranitidine)
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HOLD THE FOLLOWING HERBAL SUPPLEMENTS FOR 2 DAYS BEFORE THE TEST:

Antronex	Elderberry	Green Tea	Milk Thistle	St. John's Wort
Astragalus	Feverfew	Licorice	Saw Palmetto	

HOLD THE FOLLOWING BETA BLOCKERS FOR 2 DAYS BEFORE THE TEST ONLY WITH THE CONSENT OF YOUR PRESCRIBING PHYSICIAN:

AK-Beta (Levobunolol) eye	Betagan (Levobunolol) eye	Betaloc (Metoprolol)
Betimol (Timolol)	Betoptic (Betaxolol) eye	Blocadren (Timolol)
Brevibloc (Esmolol HCL)	Bystolic (Nebivolol)	Cartrol (Cartrolol)
Combigan (Brimonidine/Timolol) eye	Coreg (Carvedilol)	Corgard (Nadolol)
Corzide (Nadolol)	Inderal (Propranolol)	Inderide (Propranolol)
Kerlone (Betaxolol)	Levatol (Penbutolol)	Lopressor (Metoprolol)
Normodyne (Labetalol)	Ocumeter (Timolol)	Ocupress (Carteolol)
Optipranolol (Metipronolol) eye	Restoril (temazepam)	Sectral (Acebutolol)
Sorine (Sotolol)	Tenoretic (Atenolol)	Tenormin (Atenolol)
Timolide (Timolol)	Timoptic (Timolol maleate)	Toprol (Metoprolol)
Trandate (Labetolol)	Visken (Pindolol)	Zatidor (eye drop)
Zebeta (Bisoprolol)	Ziac (Bisoprolol)	

*****OMALIZUMAB (XOLAIR) MAY SUPPRESS SKIN REACTIVITY FOR UP TO 6 MONTHS*****

Patient Name: _____ **Patient DOB:** _____

PLEASE PRINT CLEARLY | BRING THIS FORM TO YOUR APPOINTMENT

What are your main allergy symptoms/ concerns? When did they start?

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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Swollen lips or tongue | <input type="checkbox"/> Coughing | <input type="checkbox"/> Ear pressure |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Scratchy throat | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Blocked ears |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Itchy throat | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Postnasal drainage | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart burn |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Throat mucus/phlegm | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> GERD (acid reflux) |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Throat clearing | <input type="checkbox"/> Hives | <input type="checkbox"/> Stomach bloating |
| <input type="checkbox"/> Swollen eyes | <input type="checkbox"/> Throat tightness | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Abdominal cramping |
| <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Swallowing difficulty | <input type="checkbox"/> Eczema | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Itchy ears | |

Are your allergy symptoms:

Year round? Yes _____ No _____

Seasonal? Yes _____ No _____ If yes, which months? _____

Does anything seem to make your allergies better or worse? _____

Are your symptoms mostly: Indoors _____ Outdoors _____ Both _____

Any reactions around: Cats _____ Dogs _____ Other animals _____ (please list)

Do you currently have any animals in your home? If yes, what and how many? _____

Have you had any form of allergy testing? Yes _____ No _____

If yes, when? _____

What were the results? _____

Have you had previous allergy treatment? Yes _____ No _____

Patient Name: _____ **Patient DOB:** _____

PLEASE PRINT CLEARLY | BRING THIS FORM TO YOUR APPOINTMENT

List any allergy, blood pressure, or antidepressant medication you are currently taking:

ALLERGY MEDS _____

BLOOD PRESSURE MEDS _____

ANTIDEPRESSANTS _____

List any FOOD allergies and reactions experienced: (e.g., nuts, shellfish, peanuts, eggs, milk)

List any DRUG allergies and reactions experienced:

List any CHEMICAL/PERFUME allergies and reactions experienced:

Are you a smoker/vaper? Yes _____ No _____ If yes, # packs per day / # years? _____

Does anyone else smoke or vape in your home? Yes _____ No _____

Do you drink alcohol? Yes _____ No _____ If yes, how much? _____

Do you live in a/an: Apartment? _____ House? _____ Townhouse / Condo? _____ Other _____

How old is the residence? _____ How long have you lived there? _____

Does anyone in your family have any of the following?
(place an X if YES)

	Asthma	Allergic rhinitis (hayfever/seasonal allergies)	Sinus problems	Food allergy	Eczema (skin problems)	Drug allergy
Mother						
Father						
Siblings						

Your bedroom floor is mostly: Wall-to-wall carpeting _____ Hardwood _____ Area rugs _____ Other _____

Your pillow: Fiber filled _____ Feather _____ Foam _____

Pillow cover (hypoallergenic): Yes _____ No _____

Mattress cover (hypoallergenic): Yes _____ No _____

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Dunedin, FL 34698
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ST. PETERSBURG (4th)

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St. Petersburg, FL 33702
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TRINITY

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