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 Unisom Vit C 500mg

TRICYCLIC ANTIDEPRESSENTS & 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 (Oleptro)
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)

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 (Propanolol)
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*****
*****PREDNISONE—ALERT ALLERGY STAFF IF YOU ARE / HAVE BEEN TAKING MORE THAN 2 WEEKS*****

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)

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