Patient Allergy Packet

Name: _____

Testing Date: _____

This packet contains the following items:

1) Allergy Financial Consent/Disclosure Form

2) Patient Allergy Profile & General Information Questionnaire

3) List of allergy medications to stop taking before allergy testing

4) List of medications which are not compatible with allergy skin testing
PLEASE NOTE: You do ***not*** need to stop taking these medications prior to testing; however, you are required to **inform the technician** if you are taking these medications.

* **Please bring this entire packet with completed forms to your allergy testing appointment along with any referral from your doctor.** If you have any questions regarding referrals, please call the clinic at any time.

* **Please DO NOT apply any lotions, oils, or other moisturizers to your arms the day of testing.**

* **Please *wear a loose/short sleeved shirt* to your appointment so that your arm may be accessed for testing and *bring any inhalers* that you are using to your testing appointment.**

* **For asthmatic patients, make sure to bring your inhaler(s) with you to your appointment.**

* Please **make a list of all the medications you are taking and share them with the Allergy Technician** during the pre-testing phone call and on testing date. This is to ensure the safety and integrity of the medical results.

NOTE: Allergy tests are scheduled for **1.5 hours** and **scheduled at least a week in advance**. This is to insure that the patient has adequate time to **stop taking certain medications prior to the allergy testing date.** If for any reason you must cancel or move your appointment time, please consider that your new appointment time must also be scheduled **at least one week** prior to testing. If you are unable to keep your appointment, please contact the clinic in advance. Any missed appointment is subject to a $50 late-cancellation fee.

Allergy Services of America, LLC

Patient Allergy Profile &
General Information Questionnaire
Chester County Otolaryngology & Allergy Associates

Carefully complete this form with full, accurate, and thorough information. Be as detailed as possible. Relate all answers to your own experiences. **This form must be completed prior to your allergy testing.**

Patient Name _____ DOB: _____

Sex: _____ Race: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Mobile Telephone: _____

☐ *I would like to receive text message reminders about upcoming appointments.*

☐ *I would **not** like to receive any text messages.*

Email Address: _____

☐ *I would like to receive emails from Allergy Services of America, LLC with updates, tips and other educational information.*

☐ *I would **not** like to receive any emails.*

Name of referring Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____

Allergy Profile

What type of allergy do you think you have?

Allergic Rhinitis: _____ Asthma: _____ Others: _____ Unsure: _____

What medications have you taken for these symptoms and for how long?

_____

If you have Asthma:

Please list all medications you are taking for it:

_____

Have any of these medications been helpful? If yes, which ones?

_____

Have you been hospitalized for asthma? Yes _____ No _____

Have you ever been allergy tested before? Yes _____ No _____

If yes, please indicate, Date: _____ Location: _____

Have you ever received allergy immunotherapy before? Yes _____ No _____

If yes, what type? Shots _____ Drops: _____

When did you start it? _____

Are you still receiving immunotherapy? Yes _____ No _____

If No, how long *were* you receiving immunotherapy? _____

Improvement after previous immunotherapy (circle) Good Fair Poor

When approximately did your Allergies begin? _____

How often do your allergies occur? _____ (# of times per day, week, etc.)

When are symptoms worse? Early morning _____ Afternoon_____ Night_____

How long do the symptoms last? _____

Check months that are most severe: All Months___

January___ February___ March___ April___ May___ June___

July___ August___ September___ October___ November___ December___

What do you think makes it WORSE?

_____

_____

_____

What do you think makes it BETTER?

_____

_____

_____

Do you think you are allergic to any foods? Yes _____ No _____ (check below)

Milk___ Cheese___ Eggs___ Fish___ Wheat Products___ Chocolate___

Shellfish___ Nuts___ Wine___ Beet___ Vegetable___ Strawberries___

Other: _____

Do you think you are allergic to any medications? Yes _____ No _____

If yes, list names of medicine _____

Type of reaction you have _____

Do you think you are allergic to any insect stings? Yes _____ No _____

Do you think you are allergic to any Latex? Yes _____ No _____

Do you have history of smoking? Yes _____ No _____

Frequency (amount smoked per day, days per week, etc.): _____ Date quit: _____

Home Environment

Home type (circle) Single Family Apartment Townhouse

Other: _____ Age of home (years): _____

Flooring (circle)	Carpet	Hardwood	Tile	Other: _____
Central air?	Yes _____	No _____		
Heating (circle)	Forced air	Radiator	Other: _____	
Indoor mold?	Yes _____	No _____		

Pets: _____

Smokers in home? Yes _____ No _____

Occupation of housemates: _____

Medical History

Do you have a history for any of the following?

1. High blood pressure Yes _____ No _____
2. Cardiovascular disease Yes _____ No _____
3. Stroke Yes _____ No _____
4. Tested positive for HIV Yes _____ No _____
5. History of severe anaphylactic reaction Yes _____ No _____

Are you pregnant? Yes _____ No _____

If there is a possibility that you are pregnant please notify the physician before you have the allergy test.

List all medications you are currently taking:

_____

_____

List all surgeries and hospitalizations:

_____

_____

Do you have family history for any of the following? (circle)

Allergies Asthma Eczema Auto-Immune Disease

Other: _____

Is there anything else you would like to mention before testing?

_____

_____

Is there anything else you would like to mention before testing?

_____

_____

Patient Notification:
Contraindicated Medications

Patients who are taking BETA-BLOCKERS (including eye drops) or TRICYCLIC ANTI-DEPRESSANTS **cannot** get *allergy skin testing*. However, these patients **can** get allergy blood testing *(RAST)*.

Below is a **partial list** of such medications. DO NOT STOP TAKING THESE MEDICATIONS UNLESS DIRECTED BY THE PRESCRIBING PHYSICIAN.

BETA-BLOCKERS:

Acebutolol(sectrol)
Atenolol(Tenormin)
Betapace(Sotalol)
Betaxolol(Kerlone)
Bisoprolol(Zebeta)
Blocardren
Bystolic(Nebivolol)
Esmolol(Brevibloc)
Carteolol HCl(Cartrol)
Carvedilol(Coreg)
Corgard
Corzide
Esmolol Inderal
Inderide
Labetalol HCl(Trandate)
Levatol
Metoprolol tartrate(Lopresor)
Nadolol(Corgard)
Nebivolol (Bystolic)
Normozide
Penbutolol Sulphate (Levatol)
Pindolol(Visken)
Propranolol(Inderal)
Sectrol
Tenoretic(atenolol&chlorthiazide)
Timolol malate(Blocarden)
Toprol
Timoptic *'Eye Drops'*
Visken

TRICYCLIC ANTI-DEPRESSANTS:

Amitriptyline(Elavil)
Desipramine(Norpramin)
Doxepim(Sinequan)
Etrafon(Perphenazine&Amitriptyline)
Limbitrol(chlordiazepoxid&Amitriptyline)
Perphenazine
Protriptyline(Vicactil)
Trimipramine(Surmontil)
Tofranil(Imipramine)

Medications to be STOPPED before Testing

The following medications must be **STOPPED** **prior to allergy testing.**

Stop the following Antihistamines 1 week prior to testing:

Alavert
Allegra (Fexofenadine)
Allegra-D (Fexofenadine & Pseudoephedrine)
Atarax (Hyroxyzine HCL)
Cetirizine
Claritin (Loratidine)
Claritin-D
Clarinex
Clarinex-D
Fexofenadine
Loratadine
Xyzal
Zyrtec

Stop the following (antihistamine sprays or drops) 3 days prior to testing:

Astelin (Azelastine) nasal spray
Astepro (Azelastine) nasal spray
Patanase (Olopatadine Hydrochloride) nasal spray
Dymista Aerosol, spray
Nasal Allergy Rinse (mediated)
Patanol (Olopatadine) eye drops
Optivar (Azelastine) eye drops

Also ***STOP TAKING*** over-the-counter allergy and cold medication such as Benadryl (diphenhydramine), Dimetapp, Tylenol PM, Exedrin PM, and any cough suppressants containing antihistamines.

H_2 blockers (such as Cimetidine, Ranitidine and Famotidine) can suppress a histamine reaction during skin testing. Therefore, when possible these medications should be **discontinued for 48 hours prior to testing.**

You may continue to use your intranasal steroid spray such as Rhinocort, Flonase, Nasonex, and Nasacort. Asthma inhalers (inhaled steroids and bronchodilator's) and leukotrienes antagonists (e.g.Singulair, Zyflo).

If you have any questions regarding these instructions, please call the clinic.

Allergy Financial Consent & Disclosure Form

Patient Name: _____

DOB: _____ Date: _____

All allergy patients are required to check with their insurance company regarding eligibility for coverage for allergy testing and treatment. Some insurance companies require co-pays for allergy testing and injections. **Please be aware that we are required to collect patient co-pays and deductibles at the time of service.**

If you wish to call your insurance company to check on your coverage for allergy testing and treatment, please provide your insurance company with the following codes to verify coverage:

Testing codes: 95004 & 95024

Treatment codes: 95165 & 95117

CANCELLATION POLICY: Due to the extended appointment time reserved for allergy testing, we must be notified within **3 business days** or a $50 cancellation fee may be charged.

Patient Signature:

_____

Relationship to patient (for minors):

_____

Witness Signature: _____

Patient Communication Consent Form

Dear patient,

Allergy Services of America, LLC is committed to finding new ways to improve the quality of care that we provide to our patients. Your feedback is key to our success and we value your opinion. ASA would like to use your feedback for training purposes with our providers and technicians at all of our locations.

An example of this would be contacting you to complete a short questionnaire about the care you received during your visit to the clinic and from time to time we may send you information on allergies and available treatment options that are available to you. We respect your privacy, your email address along with your personal information will be kept confidential and never sold or used outside this organization.

O Please contact me

O Please do not contact me

Name:_____ Email:_____

Clinic:_____