Lake Breeze ENT & Allergy

Pt. Name: _____

Allergy Test Date: _____

Time: _____ **a.m. / p.m.**

Allergy Testing Consent and Information Forms

Allergy skin testing takes approximately 1 to 1 ½ hour. Please eat a light breakfast if you are scheduled for a morning appointment. DO NOT SKIP BREAKFAST. If you are scheduled for an afternoon appointment, please eat a light lunch. DO NOT SKIP LUNCH. We use both prick and intradermal skin testing methods. This can be applied to both the arms and/or your upper back. Please wear a loose fitting, short sleeve shirt/blouse. Due to the sensitive nature and airborne particulates, we ask you to leave very young children at home or with a sitter.

Before your skin testing begins, we will ask you for a list of medications (over the counter and prescription) you have taken in the last 5 days. We will also review the allergy questionnaire that is included for you to complete, so please bring this in with you the day of your allergy test. **Attached is a sample list of medications that should be stopped 5 days prior to your allergy test date.** If you have any questions regarding a specific medication, please ask the allergy technician or staff nurse.

An Epi-Pen prescription will be called in for you prior to your allergy test. **It is necessary for you to bring your Epi-Pen with you on the day of your test. Testing may be postponed if you do not have your Epi-Pen with you.** If you have not received a prescription for an Epi-Pen, please call our office and speak with the allergy technician or staff nurse prior to your allergy test appointment. Before your allergy test, the allergy technician or staff nurse will demonstrate how to use your Epi-Pen in case of an allergenic emergency.

After the allergens are applied, the test site is checked for redness and/or "wheal" size. (Wheal is a tiny red bump that resembles a mosquito bite.) This area may itch while testing, PLEASE DO NOT SCRATCH. If no skin response results, then you are not considered allergic to the allergen you have been tested for. Results from your allergy test will be read the same day so you will know what you are allergic to. Most patients tolerate the allergy testing very well.

Once we determine what you are allergic to, we will review these results with you. It may be necessary for you to make some changes in your environment. Before you leave the office, you will have a better understanding of your allergies and what you can do to help control them.

Once your allergies have been confirmed, treatment strategies can include:

- Adding oral antihistamines and/or prescription nasal sprays.
- Decreasing exposure to the offending allergen. Avoidance is a cornerstone of allergy treatment. You may need to make some changes in your home/work environment, or even in your diet.
- If symptoms persist despite environmental changes and medication you may be a candidate for allergy immunotherapy (allergy injections).
- Each patient's allergy problems are unique. Once we confirm what substances you are allergic too, we will tailor a treatment plan that will best work for your specific allergy needs.

Please bring this form in its entirety with you the day of your appointment *(cont. next page)*

Medications to Stop for Allergy Testing

It is important to know what medications to stop prior to Allergy Testing because some medications may alter your test results.

So here is a list to stop 5 days prior to testing:

- Allegra (Fexofenadine)
- Atarax or Vistaril (Hydroxyzine)
- Zyrtec (Cetirizine)
- Actifed
- Dimetapp (Brompheniramine)
- Benedryl (Diphenhydramine)
- Chlortimeton (Chlorpheniramine)
- Clarinex (Desloratadine)
- Claritin (Alavert/Loratadine)
- Phenergan (Promethazine)
- Tavist or Antihist (Clemastine)
- Actifed
- Aller-Chlor
- Bromfed
- Drixoral
- Dura-Tab
- Novafed-A Ornade
- Poly Histine-D
- Trinalin (Combination medications)

Stop these medications the night before your allergy test:

- Singulair (montelukast), Accolate (zafirlukast)
- Zantac(ranitidine), Axid (nizatidine), Pepcid(famotidine), Tagament(cimetidine)

You may continue to take any Asthma medications. If you are on Asthma medications, please bring these with you to your appointment.

If you are taking an oral antihistamine that is not listed above, please discontinue the medication 5 days prior to allergy testing. If you are not sure a medication you are taking is an antihistamine, please call our office or your local pharmacy to verify.

If you have any questions prior to allergy testing please call us at 704-658-0595.

(cont. next page)

General List of Beta Blockers

Beta Blockers are prescription medications used to treat many different conditions such as high blood pressure (hypertension) or irregular heart rhythms (arrhythmias) or even some depression.

If you are taking any of the following medications for a medical condition, please contact our office prior to your appointment.

Telephone: 704-658-0595

Acebutolol (*Sectral*)

Atenolol (*Tenormin*)

Betaxolol (*Kerlone, Betopic*)

Bisopropol (*Zebeta*)

Esmolol (*Brevibloc*)

Nebivolol (*Bystolic*)

Metoprolol (*Lopressor, Toprol – XL*)

Carteolol (*Ocupress*)

Penbutolol (*Levatol*)

Pindolol (*Visken*)

Carvedilol (*Coreg, Coreg CR*)

Labetalol (*Trandate*)

Levobunolol (*Betagan*)

Metipranol (*Optipranolol*)

Nadolol (*Corgard*)

Propanolol (*Inderal, Inderal LA, InnoPran XL*)

Sotalol (*Betapace, Sorine*)

Timolol (*Betimol, Blocadran, Isalol, Timoptic*)

(cont. next page)

Consent for Allergy Testing

Generalized Reactions

Generalized reactions occur rarely but are the most important because the potential danger of progression to collapse and even death if not treated. These reactions may include but are not limited to:

1. **Urticarial reactions (hives)** include varying degrees of rash, swelling, and or itching of more than one part of the body. There may be mild to moderate discomfort, primarily from the itching. This uncommon reaction may occur within minutes to hours after applying antigens while performing allergy testing or an allergy injection.
2. **Angioedema** is rare and is characterized by swelling of any part of the body, inside or out, such as ears, tongue, lips, throat, intestine, hands, or feet, alone or in any combination. This may occasionally be accompanied by asthma and may progress to the most severe reaction, anaphylactic shock. In the absence of shock, the principle danger lies in the suffocation due to swelling of the airway. Angioedema may occur within minutes after applying antigens while performing allergy testing or the allergy injection and requires immediate medical attention.
3. **Anaphylactic Shock** is the rarest complication, but is a serious event characterized by acute asthma, vascular collapse (low blood pressure), unconsciousness, and potential death. This reaction usually occurs within minutes of applying antigens while performing allergy test or an allergy injection and is extremely rare.

The potential risk involved with allergy testing /immunotherapy have been explained to me, including allergic reactions, anaphylaxis, and even death. The opportunity has been provided for me to ask questions regarding the potential risks of allergy testing/ immunotherapy, and these questions have been answered to my satisfaction. I understand that precautions will be carried out to protect me from adverse reactions while allergy testing is being performed.

I do hereby give consent for the patient designated below to proceed with allergy testing/immunotherapy as prescribed by Dr. Roy Lewis, Lake Breeze ENT & Allergy.

_____(initial) I hereby give authorization and consent for treatment by Dr. Roy Lewis, Lake Breeze ENT & Allergy, and his staff, for any reactions that may occur as a result of allergy testing/immunotherapy. I have read the information in this consent form and understand it.

_____(initial) I have read the provided educational materials and had the opportunity to ask questions and have them answered to my satisfaction regarding allergy testing and immunotherapy. I understand the nature, risks, and benefits as explained above.

_____(initial) Patient/parent/legal guardian has an Epi-pen Auto-injector with them and has been instructed on how and when to use the Epi-pen Auto-injector.

_____

Printed Name of Immunotherapy Patient

_____ _____

Signature of Patient/Parent/Legal Guardian Date

Lake Breeze ENT & Allergy

ALLERGY HISTORY FORM

Pt Name: _____ **Date:** _____/_____/_____

Ordering Physician: Roy S. Lewis Name of Allergy Testing Technician: _____

(for use by office staff only)

Please place a check beside conditions that affect your symptoms

During which months do symptoms occur?

□ All Months			
□ January	□ April	□ July	□ October
□ February	□ May	□ August	□ November
□ March	□ June	□ September	□ December

Are symptoms worse?

□ Morning	□ Afternoon	□ Evening	□Night
□ At Home	□ At Work / School	□ Other Location *specify*	

Are Symptoms: **Do you:**

□ Constant □ Erratic □ Rare		Have basement in home □Y □ N	Have plants inside the home □ Y □ N
		Sleep with windows open □Y □N	Sleep on feather pillows □Y □N

Family History:

□ Asthma	□ Eczema	□ Sinus Problems	□ Migraines
□ Hay Fever	□ Ulcer	□ Nervous Disorder	□ Colitis
□ Other *specify*			

Your Medical Conditions:

□ Asthma	□ High Blood Pressure	□ Heart Disease	□ Bronchitis
□ Bee Sting Allergy	□ Thyroid disease	□ Emphysema	□ Diabetes
□ Hormonal Difficulty		□ Stomach or Intestinal problems / disease	
□ Drug Allergy, *specify*			
□ Food Allergy, *specify*		Other, *specify*	

Do any of the following, cause or make your symptoms worse?

□ Milk or milk products	□ Fruit or fruit Juices	□ Vegetables	□ Egg /egg products
□ Beer	□ Wine	□ Liquors	□ Wheat / Rye products
□ Nuts/Beans/Seeds	□ Cheese	□ Mushrooms	□ Vinegar
□ Chicken	□ Poultry	□ Fish	□ Meats
□ Other *specify*		□ Other *specify*	

Are your symptoms made worse by:

□ Wind	□ Smoke	□ Barns / Hay	□ High pollution days
□ Damp areas	□ Soap	□ Powders	□ Mowing lawns
□ Insecticides	□ Dust	□ Paint Fumes	□ Perfumes
□ Cosmetics	□ Newspapers	□ Wool	□ House plants
□ Dry weather	□ Wet weather	□ Cold days	□ Hot days
□ Weather change	□ Air-Conditioning	□ Travel / Vacations	□ Aerosol sprays
□ Indoors, explain		□ Outdoors, explain	

Do you have pets or are you exposed to other animals?

□ Cats	□ Dogs	□ Other, *specify*

Have you ever been treated with Allergy injections? □Yes □ No **If yes, did the allergy injections help your symptoms?**□ Yes □ No

What were you treated for:

□ Grass Pollens	□ Tree Pollens	□ Weed Pollens	□ Animals	□ Dust	□ Other, *specify*

What years were allergy shots taken? _____ to _____