Central Missouri Ear, Nose Throat, Sinus & Allergy, PC

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Date: _____ Name: _____

The best method of controlling allergies and allergic rhinitis is avoidance of the offending agent. Environmental controls for reducing exposure are essential. When sufficient relief can not be achieved with avoidance techniques or medications, such as antihistamines or other prescribed allergy medications, injections, which contain small doses of the offending allergen, can be administered. These injections stimulate the body's production of blocking antibodies, which then reduces your sensitivity to the allergen. Injections are often effective for pollens, dust, mold spores, and animal danders. Immunotherapy is not a cure for allergies and does not provide 100% protection or alleviation of symptoms. However, most people benefit substantially from such therapy. The patient must take an active role in allergy treatment, which includes adjusting environmental exposures and being compliant with prescribed treatment protocol.

The treatment time is uncertain due to many variables, which influence each patient's progress. Remember that you are an individual and you will react to the environment differently than others. Cooperation and communication with the allergy staff are very important factors as you progress through treatment. Also during your allergy treatment you will be put through a series of build-up injections until a safe maintenance dosage is reached. After you have been on maintenance injections for six months to one year we will schedule a follow-up appointment with your physician here to discuss your progress.

PRETESTING INSTRUCTIONS

Appointment Date: _____ **Time:** _____

Medications: Take **no** antihistamines for one (1) week prior to your allergy testing appointment. **You may continue to take SINGULAIR, as it will not interfere with your allergy testing.**

If you are currently taking any type of tricyclic antidepressant or if you are taking a beta-blocker medication, you *must* notify the allergy nurse so testing can be delayed until such medication

can be changed or discontinued. If you are unsure if your medication falls into either of these categories, please check with one of the allergy nurses.

Do not take Zantac, Pepcid, Tagamet, Axid, Nizatidine, Ranitidine, Famotidine, or Cimetidine, for **THREE** (3) days prior to testing. These medications will interfere with your test results.

You **may** continue using nasal sprays, which include nasal steroids. However, if you are using **Asteline Nasal Spray**, you need to stop using it seven (7) days prior to testing as it is an antihistamine.

NO perfumes, colognes, or body sprays.

Allergy Review of Symptoms

Patient's Name: _____

Date of Birth: _____ Age: _____

Parent's Name (if minor): _____

Today's Date: _____

Do you have any problems related to the following? Circle Yes or No

Skin:
Eczema Y N
Hives Y N
Other _____

Ears:
Popping Y N
Itching Y N
Hearing Loss Y N
Other _____

Throat:
Frequently Sore Y N
Frequent Drainage Y N
Itching Throat/Mouth Y N
Other _____

Eyes:
Redness Y N
Itching Y N
Tearing Y N
Puffiness Y N
Other _____

Breathing:
Wheezing with colds Y N
Wheezing when exposed to dust, pollen, animal, etc. Y N
Wheeze/Cough after excercise Y N
Other _____

Cough:
Deep or Productive Y N
Loose Y N
Constant Y N
Other _____

Allergies:
Moderate Y N
Severe Y N
Other _____

Which of the following do you think causes your symptoms or makes them worse?

Indoors	Y N
Outdoors	Y N
At Home	Y N
At Work	Y N
Weather Change	Y N
Damp Areas	Y N
Hay	Y N
Mowing Lawn	Y N
Dusty Environment	Y N
Animals	Y N
Smoke	Y N
Paint Fumes	Y N
Perfumes	Y N
Newspapers	Y N
Road Dust	Y N

Other _____

During what months do you usually have allergy symptoms?

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

Do you take any medications daily or frequently?

Aspirin	
Cortisone	Y N
Sedatives	Y N
Vitamins	Y N
Ointments	Y N
Nose drops/sprays	Y N

Other:

_____

_____

_____

Do you sleep with a feather pillow or have a feather mattress? Y N

Do any of your blood relatives have allergies? Y N

Have you ever had skin tests for allergies? Y N

Do you have allergies? Y N

Smoke:

Smokers in your home? Y N

Do you Smoke? Y N

If yes:

Cigarettes ____ per day

Pipe ____ per day

Cigars ____ per day

Years smoked? _____

Date stopped smoking: _____

Animal Allergies:

Do you have animals in your home? Y N

Have you ever had contact, or do you have contact with any of these animals?

Dog	Y N
Cat	Y N
Bird	Y N
Cattle	Y N
Horse	Y N

Other_____

Do you spend a good deal of time in activities? Y N

Carpentry	Y N
Camping	Y N
Gardening	

Hobbies (list):

_____

_____

_____

Sports (list):

_____

_____

_____

Is there anything else about your problem which you think might be important or unusual?

_____

_____

_____

_____

_____

Do you have or have you had in the past any of the following? If current please list medications.

High blood pressure	Y N	Asthma	Y N	Food allergies	Y N
Migraine headaches	Y N	Nasal polyps	Y N	Drug allergies (describe):	Y N
Skin disease	Y N	Emphysema	Y N		
Heart disease	Y N	Bronchitis	Y N	Other conditions (describe):	Y N
Frequent headaches	Y N	Nasal Surgery	Y N		
Sinus disease	Y N	Hay fever	Y N		
Stomach disease	Y N	Hives	Y N		