

ALLERGY/IMMUNOLOGY SERVICE INFORMATION

Please fill out the enclosed forms and bring them for your appointment. It will save you time on your appointment day. Initial allergy appointments can take long periods of time, often two hours to complete. If you have a limited time for the appointment, you may wish to reschedule.

LOCATION

The Allergy Clinic is in the Intermountain Sandy Health Center at 9500 South 1300 East. This is the northernmost building in the Alta View Health Campus. The clinic phone number is **801.501.2130**. (A map is on the enclosed sheet to help you find our location.)

MEDICATIONS

If you have a new patient appointment or a skin test appointment, you must not take **ANTIHISTAMINES** since they interfere with the test. The following medications need to be stopped **SEVEN (7)** full days before testing – Alavert, Allegra, Atarax, Claritin, Clarinex, Hydroxyzine, Vistaril, Xyzal and Zyrtec. Many cold and allergy, and sleep medications contain antihistamines. They will need to be stopped before the test. Some **ANTIDEPRESSANTS** and sleeping aids can also interfere. Please look on the back of this form for a list of most of the medications and how long they need to be stopped before the test. **BETA BLOCKERS** (usually for high blood pressure, heart problems or migraines) might cause problems during testing. If you take these medications, please inform the clinic, but do not stop them without your doctor's okay. If you are coming in for unusual testing (penicillin, other antibiotics or drugs), please be aware that the testing may not be done on your first visit.

DO NOT STOP your asthma medications. These will not interfere with the skin test.

If you have any questions or are primarily being evaluated for chronic hives, please call **801.501.2130** between 8:30 a.m. and 4:30 p.m. to speak with one of the Allergy team.

CHILDREN

If a child under 18 years old has an appointment, a parent or guardian must accompany them.

FRIENDS AND RELATIVES

There is limited space in the Allergy Clinic and in the exam rooms. We also do not have an area to entertain the children. Please keep this in mind when you come for your appointment. A certain amount of time has been allotted for each patient. If you bring other family members with you, please limit comments and questions pertinent to the *scheduled patient only* as a courtesy to the patients waiting their turn to see the doctor.

ALLERGY/IMMUNOLOGY SERVICE INFORMATION (CONTINUED)

MEDICAL RECORDS

Copies of prior allergy medical records could be very helpful for your evaluation. Please bring them with you to the appointment or have them sent or faxed to the office prior to your appointment. The fax number is **801.501.2122**.

PERFUME AND COLOGNE

Please do not wear any perfume or cologne for appointments in the Allergy Clinic. Many allergy patients are very sensitive to odors.

APPOINTMENT DAY

1. Eat a good breakfast or lunch.
2. Wear a short-sleeved blouse or shirt.
3. Bring a list of your current medications or even better, the medications themselves.
4. Bring enclosed forms, filled out.

CANCELLATION OF APPOINTMENTS

Please cancel appointments at least 24 hours ahead so we can accommodate someone else in the appointment slot. Failure to cancel an appointment may result in a charge. Repeated late cancellations or no-shows could result in you being released from the Clinic.

LATE POLICY

One of the most common complaints about physicians is that patients wait long periods of time in their office to be seen. To help prevent this, plan on arriving 15 minutes early for your appointment to check in and complete paperwork, etc., before your time to see the physician. Other patients who arrive on time and are waiting will be seen before you. If you are over 15 minutes late, we will try to work you in, but you may need to reschedule.

PATIENT MEDICAL HISTORY FORM

Please fill out those sections which apply to you prior to your visit. Also, everyone fill out the last page.

Bring this questionnaire with you. Thank you! (This questionnaire is confidential.)

MRN _____

Name: _____ Age: _____ Date: _____

Address: _____

Would you like a summary letter sent to your primary or referring doctor? Yes No

Primary Doctor: _____ Address: _____

Referring Doctor: _____ Address: _____

1. For those with **HAY FEVER, CHRONIC NASAL CONGESTION, SEASONAL ALLERGIES** or **PET ALLERGY**, please fill out this section:

Symptoms (*circle all that apply*)

NOSE: hay fever, congestion, sneezing, running, itching, polyps mattering, bleeding, loss of smell, sinus infections

EYES: itching, tearing, swelling, redness, styes

EARS: itching, blockage, infections, discharge, hearing loss, earaches

THROAT: itching, hoarseness, voice loss, infections, postnasal drip, soreness, bad breath, dryness

CHEST: asthma, cough, wheeze, mucus, tightness, short breath, pneumonia, congestion, bronchitis

When do these symptoms occur? Spring Summer Fall Winter All year long

How long have you had these symptoms? _____ years

Worsening? Yes No

Which of the following appear to cause these symptoms? (*circle all that apply*)

POLLEN: trees, grass, weeds

ANIMALS: cats, dogs, horses, other animals (*list*) _____

ODORS: detergents, soaps, hair spray, paint fumes, perfumes, tobacco smoke

OTHER: food, excitement, fatigue, medications (aspirin, etc.), inversions, cold air, exercise, infections (colds), laughing, house dust, stress, weather changes, nighttime, other (*list*) _____

PATIENT MEDICAL HISTORY FORM (CONTINUED)

Have allergy skin tests been done before? Yes No

Have allergy blood tests been done before? Yes No

Doctor: _____

Date: _____

Results: _____

Allergy shots? Yes No

From: _____ to _____ (dates)

What medications have you taken for your **hay fever/congestion** symptoms? *Please indicate response:*

Medication: _____ Helpful? Yes No Some

Medication: _____ Helpful? Yes No Some

Medication: _____ Helpful? Yes No Some

Medication: _____ Helpful? Yes No Some

2. For those with **ASTHMA/CHEST PROBLEMS:**

How long have you had these symptoms? ____ years

Worsening? Yes No

What triggers these symptoms? _____

How often do you wake at night because of cough or wheezing? _____

How often do you use "rescue" medication (i.e., albuterol)? _____ With exercise? Yes No

How long ago did you last need prednisone for your asthma? _____

How long ago did you last need urgent care for your asthma? _____

Do you use a peak flow meter? Yes No Personal best? _____

Date of last chest X-ray: _____

Date of last sinus X-ray/CT scan: _____

What medications have you taken for your **asthma** symptoms? *Please indicate response:*

Medication: _____ Helpful? Yes No Some

Medication: _____ Helpful? Yes No Some

Medication: _____ Helpful? Yes No Some

Medication: _____ Helpful? Yes No Some

PATIENT MEDICAL HISTORY FORM (CONTINUED)

3. For those with **ADVERSE REACTIONS TO FOOD:**

List specific foods and describe reaction:

Food: _____

Reaction: (*circle all that apply*) anaphylaxis, hives, wheezing, itchy mouth, throat swelling, eczema, vomiting

Other reactions: _____

When was first reaction: _____

Most recent: _____

List specific foods and describe reaction:

Food: _____

Reaction: (*circle all that apply*) anaphylaxis, hives, wheezing, itchy mouth, throat swelling, eczema, vomiting

Other reactions: _____

When was first reaction: _____

Most recent: _____

List specific foods and describe reaction:

Food: _____

Reaction: (*circle all that apply*) anaphylaxis, hives, wheezing, itchy mouth, throat swelling, eczema, vomiting

Other reactions: _____

When was first reaction: _____

Most recent: _____

List specific foods and describe reaction:

Food: _____

Reaction: (*circle all that apply*) anaphylaxis, hives, wheezing, itchy mouth, throat swelling, eczema, vomiting

Other reactions: _____

When was first reaction: _____

Most recent: _____

What treatment is usually needed? (*circle all that apply*) Benadryl, Zyrtec, Claritin, EpiPen, steroids

Do you have an EpiPen/EpiPen Jr? Yes No

PATIENT MEDICAL HISTORY FORM (CONTINUED)

4. For those with **ECZEMA:**

How old were you when this started? _____

Has it been continuous? Yes No

Intermittent? Yes No

What other symptoms are there with the eczema? (*circle all that apply*) itching, sleep problems, redness, infections

What treatment was used? (*circle all that apply*) ointments, creams, baths, wraps

What medications are used?

Topical steroids: (*list*) _____

Oral medications: (*list*) _____

5. For those with **INSECT STING REACTION:**

Insect: _____

Reaction: (*circle all that apply*) swelling, anaphylaxis, hives, wheezing, feeling faint, nausea

Insect: _____

Reaction: (*circle all that apply*) swelling, anaphylaxis, hives, wheezing, feeling faint, nausea

Insect: _____

Reaction: (*circle all that apply*) swelling, anaphylaxis, hives, wheezing, feeling faint, nausea

Other reaction: _____

Date of first reaction: _____

Most recent reaction: _____

Treatment: (*circle all that apply*)

Benadryl, Zyrtec, Claritin, EpiPen, ER, steroids

Do you have an EpiPen/EpiPen Jr? Yes No

PATIENT MEDICAL HISTORY FORM (CONTINUED)

6. For those with **HIVES/ITCHING/SWELLING**:

General Features:

Do you have **hives** or **swelling**, or **both**? (*circle all that apply*)

Date of onset: _____

Most recent episode: _____

How often do you have the hives/itch: daily, weekly, monthly

How often do you have the swelling: daily, weekly, monthly

If intermittent, how long do they last: minutes, hours, days, weeks

Time of day when symptoms are most severe: _____

Parts of body affected by hives/itch: _____

Parts of body affected by swelling: _____

Do the hives: (*circle all that apply*) itch, bruise, worsen with scratching, move daily

Do any of the following seem to be associated with the hives, itch or swelling: (*circle all that apply*)

Exercise, soap, cosmetics, detergents, latex, stress, cough, wheezing, cold, heat, sunlight, pressure, vibration, animals, indoors, outdoors, nighttime, pregnancy, daytime, at home, at work, menstrual periods, tight clothing, foods (*list*) _____

Any other specific associations? _____

Do you have any problems with the following: (*circle all that apply*)

sore throat, pneumonia, painful urination, sinus infections, yeast infections, fever, hepatitis, swollen glands, mononucleosis, skin infections, diarrhea, thyroid disease, tooth/gum infection, any autoimmune disease (*i.e., lupus, arthritis*)

Treatment:

Please indicate the treatments that have been used in the past for your hives.

Score your response to each type of therapy:

0 – No response **1** – Slight response **2** – Moderate response **3** – Complete clearing

Antihistamine _____ Steroids _____ Antibiotics _____ Diet changes _____ Other _____

PATIENT MEDICAL HISTORY FORM (CONTINUED)

Environmental Conditions:

Occupation: _____

Hobbies: _____

How long have you lived in Utah? _____

Age of home: _____ Years at present address: _____

Pets: cat, dog, bird, other (*list*) _____

Are pets indoors? Yes No

If in the house, are they in the bedroom? Yes No

Heating system: gas, electric, wood, coal, oil

Air conditioning: Yes No *If yes, what type:* central, swamp, window

Air filtering system: Yes No *If yes, what type:* central, room

Humidifier: Yes No *If yes, what type:* central, room

Fireplace: Yes No

Water damage in home? Yes No

Farm animals near home? Yes No

What kind? _____

Neighborhood: city, rural suburbs, country

Smoking History:

Smoker? Yes No

How often? _____

Daily amount? _____

How many years? _____

Other smokers at home? Yes No

Medical History: (*circle all that apply*)

Heartburn, diabetes, emphysema, glaucoma, nasal polyps, cataracts, heart disease, urine retention, ulcers,
high blood pressure, cancer (*list type*) _____

Other diseases: _____

Birth problems: _____

Growth and development problems: _____

PATIENT MEDICAL HISTORY FORM (CONTINUED)

Hospitalization/Surgery/Emergency Visits:

Reason: _____

Date: _____

Reason: _____

Date: _____

Review of General Health: *(circle all that apply)*

GENERAL: chronic fever, increased fatigue, unintentional weight loss, other _____

EYES: vision changes, itching

EARS, NOSE, THROAT: earaches, runny nose, nose bleeds, sore throat, itchy throat

LUNGS: shortness of breath, chest tightness, cough, wheeze

HEART: chest pain, abnormal heartbeat, fainting spells

SKIN: new rash, itching, easy blistering

ENDOCRINE: hot flashes, cold/hot intolerance, thirst

BLOOD/LYMPH: swollen glands, easy bruising, anemia

PSYCHIATRIC: depression, anxiety

IMMUNE SYSTEM: diagnosed immune deficiency

List any other health issues: _____

Medication: *(current medications not already listed above)*

Family History: *(please check)*

	Sisters/Brothers	Mother	Father	Children
Hay fever or other nasal allergy	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Eczema	_____	_____	_____	_____
Hives	_____	_____	_____	_____
Food allergy	_____	_____	_____	_____

Family history of other diseases: *(list)* _____

INTERFERING MEDICATIONS FOR ALLERGY TESTING

Antihistamines: Although not all individually listed, this would include **most allergy medications, PM medications, cold/flu medications.** Please check the **ACTIVE INGREDIENTS** of **ALL** the over-the-counter medications you are taking.

ACTIVE INGREDIENT	FEW EXAMPLES	WHEN TO STOP
Azelastine	Astelin, Astepro, Optivar	4 FULL days
Azatadine Maleate	Rynatan, Trinalin Repetabs	4 FULL days
Brompheniramine	Dimetane, Dimetapp, Dristan	4 FULL days
Chlorpheniramine	Allerest, Chlor-Trimeton, Comtrex, Tussionex	4 FULL days
Clemastine	Allerhist, Tavist Allergy	4 FULL days
Cyproheptadine	Periactin, PMS-cyproheptadine	4 FULL days
Dexbrompheniramine	Drixoral Allergy	4 FULL days
Diphenhydramine	Benadryl, Contac, Sominex, Tylenol PM	4 FULL days
Doxylamine	Vicks NyQuil, Unisom	4 FULL days
Olopatadine	Pataday, Patanase	4 FULL days
Pheniramine, pyrilamine	Poly-Histine Elixir, Ru-Tuss with Hydrocodone Liquid, Theraflu	4 FULL days
Tripolidine	Actifed, Triacin-C Cough Syrup	4 FULL days
* * * * *	* * * * *	* * * * *
Cetirizine	Zyrtec	7 FULL days
Desloratadine	Clarinx	7 FULL days
Fexofenadine	Allegra	7 FULL days
Hydroxyzine	Atarax, Vistaril	7 FULL days
Levocetirizine	Xyzal	7 FULL days
Loratadine	Claritin, Alavert, store name brands	7 FULL days
Promethazine	Phenergan, Phenergan with Codeine, Phenerzine, Prorex	7 FULL days

INTERFERING MEDICATIONS FOR ALLERGY TESTING (CONTINUED)

Antidepressants and Sleep Aids: *These agents must be stopped under the direct supervision of the prescribing physician and should not be abruptly terminated.*

Examples do not represent all medications of that class.

ACTIVE INGREDIENT	FEW EXAMPLES	WHEN TO STOP
Amitriptyline	Elavil, Endep, Novo-Triptyn	10 FULL days
Amoxapine	Asendin	10 FULL days
Desipramine	Norpramin	10 FULL days
Doxepin	Adepine, Sinequan	10 FULL days
Imipramine	Impril, Norfranil, Tofranil	10 FULL days
Nortriptyline	Aventyl, Pamelor	10 FULL days
Protriptyline	Vivactil	10 FULL days
Trazodone	Desyrel, Trialodine	10 FULL days
Trimipramine	Surmontil	10 FULL days

ACCEPTABLE MEDICATIONS FOR ALLERGY TESTING

The following antidepressants are acceptable and **can be continued**.

Adderall	Loxapine	Serzone
Amoxapine	Paxil	Wellbutrin
Celexa	Phentermine	Zoloft
Dibenzoxazepine	Prozac	Zyprexa
Effexor	Risperidone	

Medications that are **purely decongestants** are acceptable to continue.

If you have any questions regarding your medications, please call our office at **801.501.2130**.