Family Professional Center, P.C.

Joseph P. Rudolph MD FACEP
President
60 Terence Drive – Suite 101
Pittsburgh PA 15236

Telephone 412 653 4900
Fax 412 653 9969

Welcome to Family Professional Center, P.C. Enclosed are the items that you will need to complete and bring with you to your initial appointment. **Please completely finish all questions and place your name at the top of each page** so that you can receive the best possible treatment. Also, please note the following:

1. **Please do not take any antihistamines or decongestants for 48 hours before your appointment.**

2. Please contact your Primary Care Physician to obtain any referrals required by your insurance carrier as soon as possible **before** your appointment.

3. Visit our website www.pennallergy.com to review our notice of privacy practice located on our new patient page.

4. Please bring all insurance cards with you to your appointment.

5. Patients over the age of 18 are required to show photo identification when checking in for the first visit.

6. Any co-pays are due at the time of service.

Please visit our website www.pennallergy.com prior to your appointment for directions and additional information about allergy testing and injections.

If you have any questions or concerns please contact our office at 412-653-4900 for assistance.

Your Appointment is ______________________ at ________________

in ________________.

Pleasant Hills – 60 Terence Drive Suite 101 * Pittsburgh 15236

- **From Interstate 70:**
    - Take the Exit Route 51 Heading North (Towards Pittsburgh)
    - Travel for about 18 miles. Take Ramp marked South Park/Bethel Park
    - At the second light turn left (Sheetz Gas Station)
    - Take the first right onto Terence Drive
    - Family Professional Center is in the Yellow Building on the Right

- **From Pittsburgh from the Liberty Tunnels**
    - Take Route 51 South (towards Uniontown)
    - Travel for about 7 Miles. Take the Ramp for Curry Hollow Road
    - At the second light turn left (Sheetz Gas Station)
    - Take the first right onto Terence Drive
    - Family Professional Center is in the Yellow Building on the Right

Irwin Office – 7546 Route 30 * Irwin 15642

- **From Pittsburgh and the Turnpike**
    - Exit off of Turnpike at Irwin Exit (Route 30 – Greensburg)
    - Travel two traffic lights and start up a hill. The Dentistry Building is on the Right near the top of the hill.
    - Enter the driveway for The Dentistry Building and proceed to the Rear of the Building
    - **If you pass Kenny Ross Ford on the Left you have gone too far.**

- **From Greensburg and East**
    - Travel West on Route 30.
    - Our office is on the left just past the Adamsburg Interchange.
    - **If you reach the turnpike you've gone too far.**

Crossroads Medical Center – 3944 Washington Road * McMurray 15317

- Across Route 19 from the Waterdam Giant Eagle next to the St. Clair Hospital Outpatient Center.

For complete directions and Google Map links please visit our website at:

www.pennallergy.com

PATIENT REGISTRATION FORM

(PATIENT INFORMATION)

LAST NAME ____________________ FIRST NAME ____________________ M.I. ________

BIRTH DATE ______-______-______ PATIENT SOCIAL SECURITY # ______-______-______

ADDRESS ____________________ CITY ______________ STATE ______ ZIP ________

HOME PHONE(   )_____-_______ WORK PHONE(   )_____-_______ CELL(   )_____-_______

M [_] F [_] MARRIED:(YES)/(NO) OCCUPATION ____________ EMPLOYER__________

MINOR'S PARENT/LEGAL GUARDIAN LAST NAME ____________ FIRST ____________

PRIMARY CARE PHYSICIAN NAME ____________________ PHONE(   )____-_____

(INSURANCE INFORMATION)

PRIMARY HEALTH INSURANCE COMPANY ______________________________

IDENTIFICATION NUMBER ____________________ GROUP NUMBER ____________

INSURANCE PROVIDED BY: [__]SELF [__]SPOUSE [__]FATHER [__]MOTHER

INSURED'S NAME *(AS IT APPEARS ON INS. CARD)* ______________ ______________ ______
LAST NAME FIRST NAME M.I.

INSURED'S DATE OF BIRTH_____-_____-_____ INSURED'S SOCIAL #______-_____-______

INSURED'S ADDRESS____________________ CITY__________ STATE______ ZIP______

INSURED'S EMPLOYER ____________________ WORK PHONE (   )______-________

SECONDARY INSURANCE COMPANY ______________________________

IDENTIFICATION NUMBER ____________________ GROUP NUMBER ____________

INSURANCE PROVIDED BY: [__]SELF [__]SPOUSE [__]FATHER [__]MOTHER

INSURED'S NAME ______________ ______________ ______ ____-____-____
LAST NAME FIRST NAME M.I. DATE OF BIRTH

(CONTACT IN EMERGENCY)

LAST NAME ____________________ FIRST NAME ____________________

ADDRESS ____________________ CITY __________ STATE ______ ZIP _____

HOME PHONE(   )______-________ WORK(   )______-_______ CELL(   )_____-_______

******<u>TURN PAGE OVER, READ, AND SIGN AUTHORIZATIONS</u>******

Diagnostic Testing Notice

Family Professional Center, P.C. and Pennsylvania Allergy Associates, Inc. are professional corporations. The sole common stock holder is Joseph P. Rudolph, M.D. FACEP, incorporated under the statutes of the Commonwealth of Pennsylvania. Robinson Township Medical Associates is a sole proprietorship of Joseph P. Rudolph, M.D. FACEP.

LDS Medical Laboratory is owned and directed by Joseph P. Rudolph, M.D. FACEP. This laboratory is licensed by the Commonwealth of Pennsylvania, Department of Health.

All diagnostic and laboratory testing is performed through Family Professional Center, P.C., Pennsylvania Allergy Associates, Inc., and/or LDS Medical Laboratory. If you prefer to be referred to another laboratory or medical facility for testing we will honor your request and make provisions for such referrals.

Please notify us before any testing is begun if you prefer such a referral.

____

____

I hereby authorize direct payment of benefits to Family Professional Center, P.C., Joseph P. Rudolph, M.D. FACEP, LDS Medical Laboratory, and/or Pennsylvania Allergy Associates, Inc. I and (if married) my spouse guarantee any payment for services not covered by insurance. Any payments for services rendered by the above sent ot me will be immediately forwarded to the provider of these services. I acknowledge the privacy notification of all these providers.

Signature: ______________________________ **Date:** ____________________

Print Name: ____

Authorization of release of records. This authorization or photocopy hereof will authorize you for any purpose to release any or all information you have regarding my condition while under your observation or treatment, including the history obtained, x-ray, physical findings, diagnosis, and prognosis.

Signature: ______________________________ **Date:** ____________________

Print Name: ____

ALLERGY HISTORY QUESTIONNAIRE

Patient Name______________________________ **Birth Date**____________
Address__________________________________ **Telephone**____________

PLEASE CHECK THOSE ITEMS THAT APPLY TO YOUR ALLERGY CONDITION:

I. Age when symptoms first observed

___ 1. Infant (age 0-2)
___ 2. Child (age 3-5)
___ 3. Child (age 6-12)
___ 4. Adolescent (age 13-18)
___ 5. Adult (age 19-25)
___ 6. Adult (age 26-40)
___ 7. Adult (over 40)

II. Previous diagnosis of allergy

___ 1. Yes, and allergy shots helped
___ 2. Yes, but allergy shots did not help
___ 3. Yes, and medications helped
___ 4. Yes, but medication did not help
___ 5. None

III. Family members with allergies

___ 1. Mother
___ 2. Father
___ 3. Sister or Brother
___ 4. Grandparents
___ 5. None

IV. General medical conditions

___ 1. Depression
___ 2. Anxiety or Tension
___ 3. Frequent flu-like symptoms
___ 4. Fatigue, tiredness, or weakness
___ 5. Headaches or migraines
___ 6. Swelling of parts of the body
___ 7. High blood pressure
___ 8. Stomach or intestinal disease
___ 9. Thyroid disease
___ 10. Diabetes
___ 11. Heart trouble
___ 12. Lung trouble
___ 13. Dizziness
___ 14. None

V. Skin symptoms

___ 1. Hives
___ 2. Rashes
___ 3. Itching
___ 4. Eczema
___ 5. Fungal (athletes foot/vaginitis)
___ 6. Skin problems are rare
___ 7. Skin problems are chronic
___ 8. None

VI. Eye symptoms

___ 1. Itching
___ 2. Excessive watering
___ 3. Redness
___ 4. Swelling
___ 5. Above symptoms worse during pollen season
___ 6. Above symptoms worse with amimal exposure
___ 7. Tobacco smoke or chemical exposure makes worse
___ 8. None

VII. Ear symptoms

___ 1. Itching
___ 2. Blocking, fullness, or popping
___ 3. Hearing loss
___ 4. Pain
___ 5. Frequent ear infections
___ 6. Ear tubes inserted
___ 7. Ringing in ears
___ 8. Drainage
___ 9. None

*Patient Name*______________________

VIII. Nasal symptoms *(check & circle those applied)*

- ___ 1. Itching
- ___ 2. Sneezing
- ___ 3. Runny nose - clear
- ___ 4. Runny nose - cloudy
- ___ 5. Frequent nose blowing
- ___ 6. Above symptoms are worse during which seasons: (spring)(summer)(fall)(winter)
- ___ 7. Above symptoms are worse with animal exposure
- ___ 8. Stuffiness
- ___ 9. Post nasal drip
- ___ 10. Frequent sinus infections
- ___ 11. Nasal obstructions
- ___ 12. Loss of smell
- ___ 13. None

IX. Throat and Mouth symptoms

- ___ 1. Itching of the throat or mouth
- ___ 2. Frequent sore throats
- ___ 3. Frequent laryngitis
- ___ 4. Frequent tonsilitis
- ___ 5. Mouth sores
- ___ 6. Swelling of tongue or mouth
- ___ 7. None

X. Chest symptoms *(check & circle those applied)*

- ___ 1. Asthma or wheezing
- ___ 2. Asthma or wheezing with exercise
- ___ 3. Asthma or wheezing around animals
- ___ 4. Asthma or wheezing during pollen season
- ___ 5. Asthma or wheezing around smoke or chemicals
- ___ 6. Shortness of breath
- ___ 7. Dry coughing
- ___ 8. Wet coughing
- ___ 9. Coughing is: (day) or (night) (constant) or (intermittent)
- ___ 10. Emphysema
- ___ 11. Frequent bronchitis
- ___ 12. Frequent pneumonia
- ___ 13. Chest pain
- ___ 14. None

XI. Chronic gastrointestinal symptom

- ___ 1. Nausea and vomiting
- ___ 2. Diarrhea
- ___ 3. Gas
- ___ 4. Cramps or bloating
- ___ 5. Abdominal pain
- ___ 6. Heartburn
- ___ 7. None

XII. Frequency and severity of allergy symptoms

- ___ 1. Constant, chronic with little change
- ___ 2. Present most of the time
- ___ 3. Present part of the time
- ___ 4. Present rarely
- ___ 5. No interference with normal life
- ___ 6. Slight interference with normal life
- ___ 7. Considerable interference with normal life
- ___ 8. Prevents some normal activities

XIII. Seasons when symptoms are most severe

- ___ 1. All year long
- ___ 2. Spring
- ___ 3. Summer
- ___ 4. Fall
- ___ 5. Winter
- ___ 6. No seasonal pattern

XIV. Symptoms are worse

- ___ 1. Outdoors and better indoors
- ___ 2. At night time
- ___ 3. In the bedroom or when in bed
- ___ 4. During windy weather
- ___ 5. During damp or wet weather
- ___ 6. When the weather changes
- ___ 7. During known pollen season
- ___ 8. In certain rooms or buildings
- ___ 9. When exposed to smoke
- ___ 10. With yard work, cut grass, leaves, hay, or barns
- ___ 11. When sweeping or dusting
- ___ 12. In moldy or mildewy areas
- ___ 13. With air conditioning
- ___ 14. In fields or in the country

Patient Name________________________

XV. Symptoms are better

___ 1. After shower or bath
___ 2. With airconditioning
___ 3. Indoors
___ 4. During or after physical activity
___ 5. When it rains
___ 6. During snowy weather
___ 7. After taking antihistamines
___ 8. With allergy shots
___ 9. Don't know

XVI. Exposure to home pets

___ 1. Dogs
___ 2. Cats
___ 3. Horses or cattle
___ 4. Rodents (mice, guinea pig, etc.)
___ 5. Rabbits
___ 6. Birds or feathers
___ 7. Other________________________
___ 8. None

XVII. Exposure that causes symptoms

___ 1. Dogs
___ 2. Cats
___ 3. Horses or cattle
___ 4. Rodents
___ 5. Rabbits
___ 6. Birds or feathers
___ 7. Bees
___ 8. Other ____________________
___ 9. None

XVIII. Medication used

___ 1. Antibiotics
___ 2. Aspirin or arthritis medicine
___ 3. Antihistamines
___ 4. Over the counter nasal sprays
___ 5. Heart Medications
___ 6. Cromolyn
___ 7. Cortisone / steroids
___ 8. Decongestants
___ 9. High blood pressure medicine
___ 10. Theophylline
___ 11. Bronchodilator sprays
___ 12. Birth control pills
___ 13. Allergy shots
___ 14. Antidepressant / tranquilizer
___ 15. None

XIX. Other known allergic reactions

___ 1. Prescription Drugs
___ 2. Penicillin
___ 3. Sulfa Drugs
___ 4. Other antibiotics ____________
___ 5. Aspirin or arthritis medication
___ 6. Pain medication ____________
___ 7. Insect stings
___ 8. Immunizations and vaccines
___ 9. None
___ 10. Other ____________________
____
____

XX. Smoking habits

___ 1. Not a smoker
___ 2. Smoke one pack or less per day
___ 3. Smoke more than a pack per day
___ 4. Smoked but stopped

XXI. Food related symptoms

___ 1. Symptoms flare 5 to 60 minutes after a meals
___ 2. Awaken in the middle of the night with symptoms
___ 3. Some foods are craved
___ 4. Some foods are addictive
___ 5. The smell or odor of some foods increase symptoms
___ 6. Preservatives, additives, or food colors increase symptoms
___ 7. Some foods cause nasal symptoms
___ 8. Some foods cause rashes and hives
___ 9. Some foods cause headaches
___ 10. Some foods cause swelling of mouth or tongue
___ 11. Some foods cause upset stomach or vomiting
___ 12. Some foods cause diarrhea
___ 13. Some foods cause asthma
___ 14. Symptoms occur with restaurant foods
___ 15. None
___ 16. List all foods and type of reaction below

____
____
____
____

Patient Name ______________________________

XXII. Chemicals that cause symptoms

___ 1. Insecticides and pesticides
___ 2. Paints and household cleaners
___ 3. Perfumes and cosmetics
___ 4. Gasoline or auto exhaust
___ 5. Stove or furnace emmissions
___ 6. Emmissions around factories
___ 7. The smell of new fabric
___ 8. Chemicals in the work place
___ 9. Laundry detergent
___ 10. Newsprint
___ 11. Other ____________________
___ 12. None

XXIII. Home environment *check & circle those applied*

___ 1. Airconditioning
___ 2. Electronic air cleaners
___ 3. Humidifier
___ 4. Type of heating
(gas)(electric)(oil)
other ____________________
___ 5. Inside plants or flowers
___ 6. Types of flooring
(padded / unpadded carpet)
(hardwood)(linoleum)
other____________________
___ 7. Types of window coverings
(washable/unwashable curtains)
(shades)(venetian blinds)
other ____________________
___ 8. Wall coverings
(wallpaper)(pictures)(pennants)
(tapestries)(paneling)
___ 9. Mattress
(innerspring)(foam rubbers)
(polyester)(waterbed)
other ____________________
___ 10. Type of comforter
(cotton)(polyester)(chenille)
(downe / feather)
other ____________________
___ 11. Type of pillows
(polyester)(feather)(dacron)
(kapok)(foam)
other ____________________
___ 12. Stuffed animals

XXIV. Work environment *(check & circle those applied)*

___ 1. Airconditioning
___ 2. Electronic air cleaners
___ 3. Humidifier
___ 4. Type of heating
(gas)(electric)(oil)
other ____________________
___ 5. Plants or flowers
___ 6. Types of flooring
(padded / unpadded carpet)
(hardwood)(linoleum)
other ____________________
___ 7. Types of window coverings
(washable/unwashable curtains)
(shades)(venetian blinds)
other ____________________
___ 8. Wall coverings
(wallpaper)(pictures)(pennants)
(tapestries)(paneling)
___ 9. Work outdoors

XXV. Current Medications *(please list the following)*

Medication Name	*Dosage*	*Frequency*

XXVI. Other information you feel is pertinent to your symptoms

____
____
____
____
____
____
____
____
____
____
____

Reviewed By Doctor:

______________________________ **Date**____

Medical History

Date: ____/____/____

Name ______________________________

Address ______________________________

____

____

Occupation ______________________________

Age ______ **Birthdate** ____/____/____

Sex: [__] **Male** [__] **Female**

Home phone (_____) - _______-___________

Work phone (_____) - _______-___________

Emergency contact name _______________

Contact phone (_____) - _______-___________

[__] **Single** [__] **Widowed** [__] **Divorced** [__] **Separated** [__] **Married** **Spouse's name** _______________

Allergies to Medications, X-Ray Dyes, or Other Substances [__] **No** [__] **Yes**

(If yes, please list name of medication and type of reaction)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Medical History & Review of Systems ***(Please circle if you have had problems with or presently complaining of any of the following)***

1. Abdominal discomfort
2. Alcohol abuse
3. Anemia
4. Anxiety
5. Arthritis
6. Asthma
7. Back pain
8. Blood disorder
9. Bloody stools
10. Cancer
11. Chest pain/tightness
12. Colitis
13. Constipation
14. Cough
15. Depression
16. Diabetes
17. Diarrhea
18. Diverticulosis
19. Dizziness
20. Drug abuse
21. Ear infection-frequent
22. Ear ringing sounds
23. Eczema
24. Eye infection-frequent
25. Eye pain
26. Fainting spells
27. Fatigue-chronic
28. Foot pain
29. Gall bladder disease
30. Gout
31. Hay fever
32. Headaches
33. Heartburn
34. Heart disease
35. Heart murmur
36. Hemmorrhoids
37. Hepatitis
38. Hernia
39. High blood pressure
40. Hives
41. Hoarseness
42. Irregular Pulse
43. Indigestion
44. Kidney disease
45. Kidney stones
46. Leg pain
47. Lightheadedness
48. Memory loss
49. Mental illness
50. Muscle weakness
51. Nausea
52. Nose bleeds
53. Numbness
54. Palpitations
55. Peptic ulcer
56. Phobias
57. Pleurisy
58. Pneumonia
59. Prostate disease
60. Psoriasis
61. Rash
62. Seizures
63. Shortness of breath
64. Sinus trouble
65. Skin problems
66. Sleeping disorder
67. Sore throat-frequent
68. Stroke
69. Swollen ankles
70. T.B.
71. Thyroid disease
72. Tremors
73. Ulcer
74. Urinary disorder
75. Urinary infections-frequent
76. Urethral discharge
77. Venereal disease
78. Weight gain
79. Weight loss
80. Other _______________

____

____

____

Medications you are currently taking (Prescription, Over-the-counter, Vitamins, Herbs, Etc.)

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency

Patient Name: *Date:*___/___/___

Please List and Supply the Dates of:

Operations:_______________ _______________ _______________

_______________ _______________ _______________

Hospitalizations other than for surgery: _______________ _______________

_______________ _______________ _______________

Immunization history-have you had:

Hepatitis B? [__] No [__] Yes When?______

Tetanus immunization? [__] No [__] Yes When?_____

Polio? [__] No [__] Yes When?______

Small pox? [__] No [__] Yes When?______

Pneumovax immunization? [__] No [__] Yes When?____

Flu immunization? [__] No [__] Yes When?_________

Chicken pox? [__] No [__] Yes When?___________

Measles, Mumps, Rubella? [__] No [__] Yes When?____

Other? [__] No [__] Yes When?___________

When was your last:

Cholesterol check?________ Stool check for blood?________ Prostate exam?__________

Family History *(Has any member of your family including parents,grandparents,and siblings ever had the following)*

Illness	Which family members?	Approx. Age of illness
Cancer (describe type)		
High Blood pressure		
Heart disease		
Diabetes		
Strokes		
Migraine		
Tuberculosis		
Glaucoma		
Kidney disease		
Mental Illness		

Gynecological and Obstetric History

Age of onset of periods:______________ Frequency:___________ Length of period:_________

History of abnormal pap smear:_________ Abnormal bleeding:______ Pelvic pain:__________

Pregnancies:_______________________ Births:______________ Miscarriages:__________

Date of last pap smear:______________ Last breast exam:_______ Last mammogram:________

Prevention

Do you wear seat belts?	[__] No [__] Yes	If no why not?______________
Do you wear a bike or motorcycle helmet?	[__] No [__] Yes	[__] Does not apply
Do you smoke?	[__] No [__] Yes	If yes, how many packs per day?__________
Do you drink alcoholic beverages?	[__] No [__] Yes	If yes, how much per week?__________
Do you drink beverages with caffeine?	[__] No [__] Yes	If yes, how many per day?__________
Do you use drugs?(marijuana,cocaine,crack,etc..)	[__] No [__] Yes	If yes, explain:______________
If there is a gun in your home, is out of children's reach and unloaded?	[__] No [__] Yes	[__] Does not apply
Have you ever engaged in any activity which has put at risk of getting AIDS?	[__] No [__] Yes	If yes, explain:______________
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	[__] No [__] Yes	If yes, explain:______________
Are you in a relationship in which you have been physically hurt by your partner?	[__] No [__] Yes	
Do you ever feel afraid of your partner?	[__] No [__] Yes	
Do you have a "living will":?	[__] No [__] Yes	
Do you have a donor card?	[__] No [__] Yes	

Reviewed by Doctor_______________________________ **Date**___________

COMMON QUESTIONS ABOUT ALLERGY

JOSEPH P RUDOLPH MD, FACEP

INTRODUCTION

Your decision to seek evaluation by us is because you have symptoms which may be caused by allergies. The most common symptoms are easily recognized such as a runny nose, headache or red, itchy, watery eyes. Other symptoms are less readily recognized such as skin rashes and diarrhea. With your evaluation two goals are to be met:

1. Do your symptoms have an allergic cause?
2. Is there treatment which will improve your condition?

WHAT IS THE IMMUNE SYSTEM?

Your immune system protects your body against invasion by foreign materials and infections. The blood component of the immune system produces proteins to fight these invaders. There are three families of these proteins called immune proteins. Group G (IgG) fights bacteria, group M (IgM) fights viruses and group A (IgA) fights influenza.

WHAT ARE ALLERGIES ?

Allergic patients have a special response to foreign proteins which enter their body. These reactions do not occur in non-allergic patients. These proteins range from dust, pollens and danders to foods and certain protein medications. When the protein enters the body through inhalation, ingestion (eating) or contact with the skin, they are attacked by a special immune protein called IgE. Only patients with allergies make enough IgE to have symptoms. The reaction of IgE to these proteins release **histamine** which spreads through your blood stream to produce the symptoms. You can not have allergies without making IgE.

It is the effect of **histamine** and similar chemicals which cause your **symptoms**. Because of the large number of symptoms which may be caused by allergies, we ask that you complete a four page questionnaire which provides in depth information in many areas without missing any important questions. Each patient is unique in their response from histamine. Please be thorough with your medical history.

WHY ME?

If you have allergies it is because your parents gave you the genetic ability to make IgE. However, you will not have symptoms until you build up enough IgE to produce symptoms. The time it takes to reach this point varies in all patients. That is why some children develop symptoms when they are 3 years old and some patients do not show symptoms until they are adults.

WHAT TESTING IS PERFORMED ?

The testing performed is to determine what you are allergic to and what effects the allergies have on your system. This testing is based on your medical history and physical examination so be very thoughtful in answering your medical history. Blood testing is utilized to actually measure the IgE to various allergens, both foods and inhalants. Skin testing measures histamine release to specific antigens. Each skin or blood test is for a specific allergen. In addition, secondary effects from allergies are measured by testing such as sinus and/or chest x-rays, breathing tests and hearing tests.

DO I GET ALL THOSE NEEDLES ?

NO. We are able to limit the number of skin tests performed with our testing techniques. In addition, those skin tests which are performed are not painful. With other practitioners, as many as 100 needle tests have been performed. This will not occur with us.

WHAT DO THE TEST RESULTS TELL ME?

The medical history, physical examination and specific allergy testing will guide us in determining if allergies are contributing to your symptoms. All factors must be included in the analysis as there is not one specific test which will provide the answers to your questions.

WHAT IS THE TREATMENT?

Treatment is directed at the specific allergies and symptoms. Because histamine is the final active chemical agent in allergies, people with minor allergies can take an antihistamine to block the histamine and obtain relief. Most people try this themselves and only after antihistamines fail do they seek specialty care. We will initiate a program of antihistamines at the beginning of your care.

In addition to antihistamines, supplemental medications may be used such as medicines to treat wheezing, ointments for skin rashes and medications for nasal congestion. Antibiotics may be needed for active infections.

The basic medical treatment is desensitization using a serum of antigens formulated for the patient (allergy shots). The allergy testing has delineated your allergies. The serum contains the exact inhalants to which you are allergic and are given to you by injection using a tiny needle. Your body then builds a resistance to these allergens and your IgE will slowly begin to decrease.

Unfortunately, only minute amounts of serum may be given. Otherwise we will give you allergic symptoms. Slowly, the concentration of the serum is increased. It takes 10 weeks to go through one vial of serum. Each successive vial is ten times stronger than the first. Sometimes, it takes up to one year to build up a strong enough effect for relief of symptoms.

Food allergies can not be treated with desensitization. The only treatment is to avoid foods that are listed for you for the period stated in your treatment program.

HOW LONG DO I NEED TREATMENT WITH ALLERGY SHOTS?

Treatment continues until all of your symptoms are relieved and your IgE levels have significantly decreased. Your schedule of injections is then tapered. However, each treatment program is prescibed according to the specific needs of each patient. There is no set treatment plan. Typically, the injections are weekly for the first two years. But again, this will vary with each patient.

WHAT IF I HAVE QUESTIONS?

The primary goal is to educate our allergic patients. Allergies never go away. Each patient's program is different and varies with time. For example, some patients are very allergic to dust mites and house dust and require strict enviromental programs to keep their homes as free of dust as is possible. Others require special diets. Please give us a call if you have any questions. Your questions are important to us to provide an effective treatment program for you.

Joseph P. Rudolph MD, FACEP

412 653 4900