Allergy Testing & Treatment

This packet contains instructions for allergy testing and treatment. Please return all of this with you to your appointment.

Please bring the following with you to your appointment:

- Insurance Card / Cards
- Drivers License
- List of All Medications
-

DO NOT TAKE THESE MEDICATIONS <u>ONE WEEK PRIOR TO TESTING</u>:

Allegra (Fexofenadine)	Chlor-Trimeton	Hismanal (Aztemizole)	Tavist
Actifed (Chlorpheniramine)	Claratin (Loratadine)	Optivar Eye Drops	Tylenol Allergy Sinus
Astelin Nasal Spray	Clarinex (Desloratadine)	Patanase Nasal Spray	Tylenol Cold & Flu Nightime
Astepro Nasal Spray	Dimetapp	Patanol Eye Drops	Zantac (Ranitidine)
Atarax (Hydroxyzine)	Dramamine or Meclizine	Pepcid (Famotidine)	Xyzal (Levocetirizine)
Benadryl (Diphenhydramine)	Elestat Eye Drops	Tagament (Cimetidine)	Zyrtec (Cetirizine)

DO NOT TAKE THESE MEDICATIONS THE <u>MORNING OF THE VISIT</u>:

Accolate (Zafirlukast)	Singulair (Monteleukast)	Zyflo (Zileuton)

MEDICATIONS THAT MAY BE TAKEN:

Advair	Azmacort	Nasacort	Qvar
Aerobid	Combivent	Nasalide	Rhinocort
Albuterol (Pro-Air, Proventil, Ventolin)	Dulara	Nasonex	Symbicort
Alvesco	Duoneb	Omnaris / Zetonna (Ciclesonide	Veramyst
Atrovent (Fluticasone)	Flonase (Fluticasone)	Pulmicort	Xoponex (Levalbuterol)
Asmanex	Maxair	Qnasal (Beclomethasone)	

OTHER MEDICATIONS THAY MAY INTERFERE WITH TESTING: (If you are taking any of these medications, please call to receive special instructions prior to discontinuing. DO NOT discontinue unless instructed by a physician.)

Amitriptyline (Elavil, Endep, Triavil, Limbitrol)	Doxepin (Prudoxin, Silenor, Zonalon)	Promethazine (Phenergan)	Trimipramine (Surmontil)
Amoxapine (Asendin)	Imipramine (Tofranil)	Protriptyline (Vivactil)	
Clomipramine (Anafranil)	Nortriptyline (Pamelor)	Quetiapine (Seroquel)	
Desipramine (Norpramin)	Prochlorperazine (Compazine)	Trazodone	

ORAL STEROIDS: Call us if you are on more than 20mg of Prednisone or 16mg of Medrol per day. DO NOT discontinue unless instructed by a physician.

If you take beta blockers (see attached list), you cannot have allergy testing or injections. Please discuss this with the Allergy Department before your testing or injections. You will need to notify the staff if you have any cardiac problems, take cardiac medications, or have a pacemaker.

The skin testing appointment generally takes 1 ½ - 2 hours and will be an intra-dermal test on the arms. Please make sure to wear a short sleeve or sleeveless shirt. If it is necessary to cancel your test, please notify us 24 hours prior to the appointment. Please complete the history form and other paperwork you were given and bring with you to the appointment.

If you have any questions, please call us at (731)286-4300 and ask for the Allergy Department.

Thank you.

Dyersburg Skin & Allergy Clinic, 1950 Cook Street, Ste, B, 710 Hwy 51 ByPass, Dyersburg, TN, 38024

Allergy Testing & Treatment

BETA BLOCKERS	
Generic Name	**Brand Name**
Acebutolol	Sectral
Atenolol	Tenormin
Betaxolol	Kerlone, Betopic
Bisoprolol	Zenbeta
Esmolol	Brevibloc
Nebivolol	Bystolic
Metoprolol	Lopressor, Toprolol XL
Carteolol	Ocupress
Penbutolol	Levatol
Pindolol	Visken
Carvedilol	Coreg
Labetalol	Trandate
Levobunolol	Betagan
Metipranolo	OptiPranolol
Nadolol	Corgard
Propranolol	Inderal, Inderal LA, Innopran XL
Sotalol	Betapace, Blocadren, Istalol, Timoptic
Timolo	Brevibloc

EYE DROPS CONTAINING BETA BLOCKERS	
Generic Name	**Brand Name**
Levobunolol	Betagan, AK Beta
Betaxolol	Betoptic
Metipranolol	Potipranolol
Caretolol	Ocupress
Timolol	Timpotic

Please mark the appropriate choice and sign below:

☐ I am taking / using_____ from the medications listed above.

☐ I am not taking any of the medications listed above.

_____ _____

Signature of Patient / Guardian Date

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Informed Consent For Allergy Immunotherapy

Allergy immunotherapy shots contain water extract of pollen, mold, or dust to which a patient has been shown to be allergic by skin testing. With any type of injections, as with other substances injected into the body, there may be a "shot reaction". These generally are mild and include:

- Burning or itching at the injection site
- Swelling or hives at the injection site
- Generalized hives (welts)
- Nasal congestions and / or "runny nose" with inching of ears, nose, or throat and / or sneezing
- Itchy, watery, or red eyes

Occasionally, more severe reactions include:

- Swelling of tissue around the eyes, tongue, or throat
- Stomach or uterine (menstrual-type) cramps
- Wheezing, cough, and shortness of breath

Rare complications are:

- Abnormalities of the heart beat
- Loss of ability to maintain blood pressure and pulse

Severe reactions involving the heart, lungs, and blood vessels, could be fatal. However, if recognized and treated early, the risk is reduced.

Experience has shown that the overwhelming majority of reactions which require emergency treatment occur within 30 minutes of an injection. It is for this reason that all patients who receive such injections must remain for 30 minutes in our waiting area until checked.

Punctuality and compliance are important! It is dangerous to deviate from the prescribed schedule as there is an increased risk of a complicated reaction to the allergen solution if it is given after a prolonged interval from the previous injection. For your own safety, you should keep your appointments.

I am aware that allergy injections MUST NOT be given to patients taking or using "Beta Blockers". I have been provided a list of beta blocker medications and am currently NOT taking one of these drugs. If I begin to take any of these medications in the future, I will inform the allergy nurse at that time. I understand that beta blockers increase the likelihood of a severe reaction and make those reactions more difficult to reverse.

I herby give consent to Dyersburg Skin & Allergy Clinic for allergy immunotherapy and I further consent to the performance of such additional procedures as are indicated and considered necessary in the judgment of the treating Physician, Nurse Practitioner, or Physician Assistant to treat any reactions to the allergy injection.

I have been fully informed of the risks connected with the performance of allergy immunotherapy.

IN SIGNING THIS STATEMENT, I ACKNOWLEDGE THAT I HAVE FULLY READ AND UNDERSTAND THE INFORMATION THAT IT CONTAINS, AND THAT I HAVE BEEN ABLE TO HAVE ANY QUESTIONS ANSWERED BY ONE OF THE ALLERGY NURSES, PHYSICIAN, OR PHYSICIAN ASSISTANT.

_____ _____

Signature of Patient / Guardian Date

Dyersburg Skin & Allergy Clinic, 1950 Cook Street, Ste, B, 710 Hwy 51 ByPass, Dyersburg, TN, 38024

ALLERGY QUESTIONNAIRE

Patient Name: _____ **Date of Birth**: _____

How were you referred: ❑ Physician ❑ Self ❑ Other_____

What problem brings you to appointment today:

_____

_____

When did symptoms begin: _____

Have you been allergy tested before: ❑ Yes ❑ No

Have you had allergy treatment before: ❑ Yes ❑ No

Please check **ANY** conditions that you have had:

❑ Blocked Ears	❑ Hives / Swelling	❑ Sinus Infections
❑ Chest Tightness	❑ Itchy Nose	❑ Sneezing
❑ Cough	❑ Itchy / Watery Eyes	❑ Snoring
❑ Ear Infections	❑ Nasal Congestion	❑ Other
❑ Eczema	❑ Nasal Polyps	_____
❑ Excessive Phlegm	❑ Post-Nasal Drip	_____
❑ Fatigue	❑ Runny Nose	_____
❑ Headaches	❑ Shortness of Breath	_____

Please check ANY of the following that may TRIGGER your symptoms:

❑ Aerosol Sprays	❑ Horses	❑ Perfumes
❑ Basements	❑ Humidity	❑ Pollution
❑ Cats	❑ Insecticides	❑ Smoke
❑ Cold Air	❑ Leaves	❑ Weather Changes
❑ Cosmetics	❑ Mold / Mildew	❑ Other:
❑ Dogs	❑ Odors	_____
❑ Grass	❑ Other Animals	_____
❑ Hay		_____

Are your symptoms worse: ❑ Seasonally ❑ Year Round

When you are away from home, are your symptoms: ❑ Better ❑ Worse

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ALLERGY QUESTIONNAIRE

Patient Name: **Date of Birth**:

Environmental Survey

Do you live in a: ❑ House ❑ Condo ❑ Townhouse ❑ Apartment ❑ Duplex

Where do you live? ❑ City ❑ Rural

Number of indoor plants:

Age of house:

House construction: ❑ Brick ❑ Wood ❑ Other:_____

Is your home / apartment excessively humid: ❑ Yes ❑ No

Any water leaks / mold contaminations: ❑ Yes ❑ No

Type of heating: ❑ Space Heater ❑ Baseboard ❑ Electric ❑Other:_____

Type of air conditioning: ❑ Central ❑ Window ❑ Other:_____

Flooring in your home: ❑ Carpet ❑ Wood ❑ Other:_____

Do you have any: ❑ Stuffed Furniture ❑ Feather Comforters

Is your pillow: ❑ Feather ❑ Foam ❑ Other:_____

Is your mattress: ❑ Foam ❑ Cotton ❑ Water ❑ Innerspring & Cotton ❑ Encased in Plastic ❑ Other:_____

Do you have pets: ❑ Dogs ❑ Cats ❑ Other:_____

How Old is Your Mattress: _____

Problems with roaches or mice: ❑ Yes ❑ No

Past Medical History

Any Hospitalizations:

Have you had your tonsils or adenoids removed: ❑ Yes ❑ No

Have you had ear / nose / throat surgery: ❑ Yes ❑ No

Food Allergies and Reactions Experienced:

Drug Reactions Experienced: ❑ Penicillin _____ ❑ Sulfa _____ ❑ Aspirin _____ Other: _____

Describe any reactions to insect stings:

Check all that apply to you:

- ❑ Diabetes
- ❑ Heartburn / Reflux
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Migraines
- ❑ Asthma
- ❑ Glaucoma
- ❑ Gynecological Problems
- ❑ Loss Of Hearing
- ❑ Liver Disease / Hepatitis
- ❑ Cancer
- ❑ Thyroid Disease
- ❑ Osteoporosis
- ❑ Bleeding Disorder
- ❑ Hay Fever
- ❑ Kidney / Bladder Disease
- ❑ Emphysema
- ❑ Eczema
- ❑ Peptic Ulcer
- ❑ Heart Problems
- ❑ Seizures
- ❑ Arthritis
- ❑ Anemia
- ❑ Depression
- ❑ Anxiety
- ❑ Cataracts