Trinity Allergy, Asthma and Immunology Care, P.C.

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Medications to stop before allergy skin test appointment

Antihistamines including prescription and over the counter ones will negatively affect the outcome of skin tests. These medications have to be stopped as outlined below before you show up for a skin test appointment. As the skin tests are usually done on the same day as your first visit to our office, it is important that you consider the information below before scheduling an appointment. Remember many over the counter cold and cough medications, sleep-aids, acid reducers/ heartburn medications and eye drops contain antihistamines and have to be stopped as well before skin test appointment. If you are not sure about the nature of your medications, please check with your pharmacist. Get permission from your doctor before stopping your or your child's medications. If the antihistamine medications are not stopped required number of days before the appointment, you will not be able to complete the skin test on the day of appointment and the test may have to be postponed or other options may be considered.

- **Stop these oral antihistamines for 7-10 days before your appointment:**
  - ☒ Alavert® (Loratadine)
  - ☒ All Antihistamine Allergy Relief Eye Drops (Patanol, Pataday, Optivar, Azelastine, Zaditor etc. Call us if you are not sure). DO NOT STOP GLAUCOMA DROPS.
  - ☒ Allegra® (Fexofenadine)
  - ☒ Astelin or Astepro ® nasal spray (Azelastine nasal spray)
  - ☒ Astelin® (Azelastine)
  - ☒ Clarinex® (Desloratadine)
  - ☒ Claritin® (Loratadine)
  - ☒ Dymista® nasal spray
  - ☒ Loratadine (Claritin, Alavert)
  - ☒ Xyzal® (levocetirizine)
  - ☒ Zyrtec® (Cetirizine)
- **Stop these oral antihistmanines for 4 days before your appointment:**
  - ☒ Actifed
  - ☒ Antihist
  - ☒ Atarax®, Vistaril® (Hydroxyzine)

- ☒ Azatadine (Optimine, Trinalin)
- ☒ Benadryl (Diphenhydramine)
- ☒ Bromfed
- ☒ Brompheniramine
- ☒ Cabinoxamine (Rondec)
- ☒ Chlopheniramine (Chlortrimeton)
- ☒ Clemastine (Tavist)
- ☒ Cyproheptadine (Periactin)
- ☒ Deconamine
- ☒ Desloratidine (Clarinex)
- ☒ Dimenhydrinate (Dramamine)
- ☒ Dimetapp
- ☒ Diphenhydramine (Benadryl)
- ☒ Diphenylpyraline (Hispril)
- ☒ Doxylamine (Bendectin, Nyquil)
- ☒ Drixoral
- ☒ Dura-tab
- ☒ Hydroxyzine (Atrax, Vistaril, Marax)
- ☒ Kronofed
- ☒ Meclizine (Antivert)
- ☒ Methdilazine HCl (Tacaryl)
- ☒ Naldecone
- ☒ Novafed-A
- ☒ Ornade
- ☒ Phenergan (Promethazine)
- ☒ Phenindamine (Nolamine, Nolahist)
- ☒ Pheniramine (Polyhistine D)
- ☒ Poly-Histine-D
- ☒ Promethazine HCl (Phenegan)
- ☒ Pyrilamine (Kronohist, Rynatan)
- ☒ Rynatan
- ☒ Tavist
- ☒ Trimeprazine (Temaril)
- ☒ Trinalin
- ☒ Triprolidine (Actifed)

❖ If you are taking an **oral** antihistamine that is not listed above stop the medicine for **3-4 days** before your appointment. If you are not sure if the medicine you are taking is an antihistamine, ask your doctor or pharmacist.

❖ **<u>Stop these medications 1-2 days before your appointment:</u>**

- ☒ Axid® (nizatidine)
- ☒ Pepcid® (famotidine)
- ☒ Tagamet® (cimetidine)
- ☒ Zantac® (ranitidine)

- Some **antidepressants** can also act as antihistamines. Let us know if you are on any antidepressants before skin testing. **Do not stop antidepressants** for any reason without checking with your doctor first.
- **The following medications should not be stopped:**

  Do not stop any of your asthma medications or inhalers.

  - ☒ Cromolyn (Intal) and Nedocromil (Tilade),
  - ☒ Inhaled (Beconase, Vancenese, Nasalide, Fluticasone, Nasacort, Beclovent, Vanceril, Aerobid, Azmacort, Pulmicort, Flovent, Qvar, Symbicort, Dulera, Advair)
  - ☒ Oral Corticosteriods (Prednisone, Medrol)
  - ☒ Pseudoephedrine
  - ☒ Theophylline

Continue to take all your other medications as you normally do. Do not stop any medication without checking with your doctor first. Usually we do control skin tests first before doing full panel skin tests to ensure that your body does not have any interfering medications at the time of testing. If you are not sure about the need for stopping a medication, please call our office or the prescribing physician's office before you stop them.

If you have questions, please call our office for clarification at 928-681-5800.

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NEW PATIENT HISTORY FORM

Please answer all questions. Print and bring this form with you at the time of your appointment. Do not mail.

Name _____ Date of Birth _____ Home Phone _____

Age _____ Sex _____ Referring Doctor/ Person _____Insurance:_____

Primary Care Physician _____ Pharmacy _____

1. **Please tell us why you want to consult us. Please write down.**

_____
_____
_____
_____

2. **Did you undergo previous allergy evaluation and allergy injections in the past? ☐ Yes No ☐**

Where	When	Outcome

3. **<u>Only</u> list medications that you have tried for treating allergies or asthma.**

Medications that helped your allergy/asthma	Medications that did not help your allergy/asthma

4. **List of <u>all medications</u> [prescription and over-the-counter] that you are currently taking from all providers.**

Medication	Dose	Times daily	Start date	Any side effects?

5. Do you have symptoms referable to the <u>eyes</u>? Check all that apply. ☐ I have none

☐Bright light bothers your eyes	☐ Get crusty secretions in the eyes	☐ Had eye surgery
☐ Eyes feel dry	☐ Rash on the eyelids	☐ Wearing glasses
☐ Eyes are itching	☐ Swelling of eyelids	☐ Wearing contact lenses
☐ Eyes are red	☐ Have glaucoma	☐ Using eyedrops
☐ Eyes are watering frequently	☐ Have cataracts	☐ Regularly following up with eye Dr.

6. Do you have any symptoms referable to the <u>nostrils/ Sinuses</u>? Check all that apply. ☐ I have none

☐ Itching of the nostrils	☐ Dozing off during daytime	☐ Using CPAP/BiPAP
☐ Frequent sneezing	☐ Reduced sense of smell	☐ Sinus infections 1-3 times per year
☐ Clear runny nose	☐ Frequent nosebleeds	☐ Sinus infections 4-6 times per year
☐ Discolored nasal mucus	☐ Blood stained nasal secretions	☐ Sinus infections more than 6 times per year
☐ Postnasal drip	☐ History of nasal polyps	☐ CT scan of the sinuses within the last 2 years
☐ Nasal congestion	☐ History of deviated nasal septum	☐ CT scan normal
☐ Nasal stuffiness	☐ History of cauterization of the nose	☐ CT scan abnormal
☐ Mouth breathing	☐ History of sinus surgery	☐ ENT doctor follow-up within the last 2 years
☐ Loud snoring	☐ History of polyp surgery	☐ ENT evaluation was normal
☐ Restless sleep	☐ History of surgery for deviated nasal septum	☐ ENT evaluation was abnormal
☐ Feeling fatigued	☐ History of trauma to the face	☐ ENT Dr. recommended allergy evaluation
☐ Feeling irritable	☐ History of hole in the nasal septum	☐ ENT Dr. recommended surgery
☐ Having poor concentration	☐ Have sleep apnea	

7. Do you have any symptoms referable to the <u>throat</u>? Check all that apply. ☐ I have none

☐ Have bad breath	☐ Frequent sore throats	☐ Had tonsils removed
☐ Constant postnasal drip	☐ Frequent strep throats	☐ Had adenoids removed
☐ Clear throat frequently	☐ Frequent tightening of throat	☐ Had surgery for sleep apnea
☐ Frequent hoarseness of voice	☐ Frequent choking	☐ Frequent cold sores in the mouth
☐ Roof of the mouth itches	☐ Throat feels dry on waking up	☐ Frequent canker sores in the mouth

8. Do you have any symptoms referable to the <u>ears</u>? Check all that apply. ☐ I have none

☐ Inside of the ears itch	☐ Ear infections 4-6 times per year	☐ History of ear tubes placement
☐ Ears plugged up frequently	☐ Ear infections greater than 6 times per year	☐ History of ear surgery
☐ Ears pop frequently	☐ Reduced hearing	☐ Have/had speech impairment
☐ Frequent earaches	☐ Frequent dizziness	☐ Have received speech therapy
☐ Ear infections 1-3 times per year	☐ Ringing/buzzing in the ears	☐ Wear hearing aids

9. Check all that apply if you have headaches. ☐ I have none

☐ Headache onset less than one year	☐ **Headaches predominantly affect one side**	☐ **Wakes up with headaches during night**
☐ Headache onset 1-5 years	☐ Headaches predominantly affect both sides	☐ **Family history of migraine present**
☐ Headache onset greater than 5 years	☐ **Nausea with headaches**	☐ **Had eye examination within the last one year**
☐ **Headaches getting worse**	☐ Vomiting with headaches	☐ CT/MRI of the head done
☐ Headaches about the same	☐ Bright light bothers headaches	☐ CT/MRI of the head Normal/ abnormal
☐ Headaches getting better	☐ Loud noise bothers headaches	☐ Take Aspirin/ Tylenol/ NSAID/Pain Medication
☐ **Headaches severity _____/10**	☐ Get visual aura before headaches	☐ Seen by a neurologist within the last 2 years

10. Do you have any of the following <u>chest</u> symptoms? Check all that apply. ☐ I have none

☐ **Cough**	☐ Cough productive of blood	☐ **Last chest x-ray was in the last one year**
☐ Wheezing	☐ **History of tuberculosis**	☐ Chest x-ray normal/abnormal
☐ Tightness of chest	☐ History of Valley fever	☐ Last chest CT scan within the last 2 years
☐ Shortness of breath	☐ History of pneumonia	☐ CT scan of chest normal/abnormal
☐ Nighttime cough	☐ History of pneumonia	☐ **Current smoker**
☐ **Cough following exertion**	☐ History of croup	☐ Ex-smoker
☐ Cough following laughing and talking	☐ History of RSV positive bronchiolitis	☐ Exposed to secondhand cigarette smoke
☐ Cold air makes me cough	☐ History of foreign body aspiration	☐ **Current on influenza vaccine for the year**
☐ Cough more during spring and fall	☐ History of frequent diarrhea	☐ Current on pneumonia vaccine within the last 5 years
☐ Cough more after eating food	☐ **History of emphysema/COPD**	
☐ **Cough productive of white mucus**	☐ History of asthma	
☐ Cough productive of discolored mucus	☐ **Followed by a pulmonary physician**	

11. Do you have any of the following <u>acid reflux</u> symptoms? Check all that apply. ☐ I have none

☐ **Frequent heartburn**	☐ History of Vomiting fresh blood	☐ Taking acid reducing pills
☐ Frequent burping/belching	☐ History of passing black tarry stools	☐ **Upper GI Endoscopy within the last 5 years**
☐ Bringing up food in the mouth after eating	☐ Frequent upper abdominal pain	☐ History of H. pylori infection in the past
☐ Painful swallowing	☐ **Taking NSAIDs frequently**	
☐ Food getting struck while eating	☐ Taking antacids frequently	

12. Do you have any of the following <u>skin</u> symptoms? Check all that apply. ☐ I have none

☐ **Rash**	☐ Rash affecting upper back	☐ Rash worse after menstruation
☐ Itching	☐ Rash affecting lower back	☐ Rash worse after alcohol
☐ Hives/Welts	☐ Rash affecting thighs	☐ Rash worse after dry fruits
☐ Swelling of the eyes, lips, tongue, throat, hands, feet or genitals	☐ Rash affecting legs	☐ **Rash is accompanied by cough**
☐ Eczema	☐ Rash affecting feet	☐ Rash is accompanied by wheezing
☐ Contact dermatitis	☐ **Rash is red**	☐ Rash is accompanied by difficulty breathing

☐ Dryness of skin	☐ Rash is flat	☐ Rash is accompanied by tightness of throat
☐ Skin peeling	☐ Rashes raised	☐ Rash is accompanied by swelling
☐ Skin blisters/blebs	☐ Rash is blistering	☐ Rash is accompanied by stomach cramps
☐ **Rash affecting scalp**	☐ Rash appears pussy and scabbed	☐ Rash is accompanied by diarrhea
☐ Rash affecting the fore head	☐ Rash is discrete	☐ Rash is accompanied by fatigue
☐ Rash affecting cheeks	☐ Rash is diffuse	☐ Rash is accompanied by fever
☐ Rash affecting ears/behind ears	☐ **Rash is made worse by scratching**	☐ Rashes accompanied by weight loss
☐ Rash affecting around mouth	☐ Rash is made worse by sunlight	☐ Rashes accompanied by joint symptoms
☐ Rash affecting eyelids	☐ Rash is made worse by tight clothes	☐ **Family history of hives present**
☐ Rash affecting neck	☐ Rash is made worse by heat and sweating	☐ Family history of swelling present
☐ Rash affecting chest	☐ Rash is made worse by hot showers	☐ Family history of hypothyroidism
☐ Rash affecting the abdomen	☐ Rash is worse in cold weather	☐ Personal history of hypothyroidism
☐ Rash affecting genitals	☐ Rash is worse in the summer	☐ Personal history of hyperthyroidism/Graves' disease
☐ Rash affecting the buttocks	☐ Rash is worse at night	☐ Personal history of goiter
☐ Rash affecting arms	☐ **Rash is made worse by mechanical pressure to skin**	☐ Personal history of lupus/RA
☐ Rash affecting elbows	☐ Swelling is made worse by minor trauma	☐ Personal history of liver disease
☐ Rash affecting forearms	☐ Swelling is made worse by surgery	☐ Personal history of kidney disease
☐ Rash affecting hands	☐ Swelling is made worse by dental work	☐ Personal history of diabetes mellitus
☐ **History of skin warts**	☐ **Started new prescription medication for the rash appeared**	☐ **Name of the soap used**
☐ History of scabies	☐ Taking aspirin	☐ Name of the shampoo used
☐ History of ringworm	☐ Taking NSAIDs	☐ Name of the lotions used
☐ History of skin yeast infection	☐ Taking fiber pills	☐ Name of the sunscreen used
☐ History of frequent cold sores in the mouth	☐ Taking laxatives	☐ Name of the detergent used
☐ History of HIV	☐ Taking herbs	☐ Using Clorox/bleach in the laundry
☐ History of sexually transmitted diseases	☐ Taking hormone pills/injections	☐ Using Bounce/Downy in the dryer
☐ History of hepatitis C	☐ Taking birth control pills	☐ **Evaluation by a dermatologist within the last one year**
☐ History of hepatitis B	☐ Taking suppositories	☐ Had biopsy of skin
☐ **Allergic to poison ivy**	☐ Taking vitamins	☐ Received steroid injection
☐ Allergic to nickel	☐ Taking supplements	☐ Received steroid pills
☐ Allergic to cosmetics	☐ Have dental implant	☐ Last date of steroid injection/pills
☐ Allergic to Neosporin	☐ Have surgical implant	☐ Dermatologist recommended allergy evaluation
☐ Allergic to latex	☐ Any changes in cosmetics before the onset of rash	☐ Dermatologist recommended patch testing
☐ Allergic to new clothes	☐ Any changes in skin and body care products before the onset of rash	
☐ Allergy to wool	☐ **Using topical steroid creams**	
☐ Allergic to leather	☐ Using topical Benadryl cream	
☐ Allergic to deodorants/perfumes	☐ Using topical anti-itch medication	
☐ Allergic to hair dye	☐ Using topical Neosporin	
☐ Allergic to nail polish	☐ Using emollients	
☐ Allergic to eye makeup	☐ Using sunscreens	

13. Which of the following triggers affect your allergy symptoms? Check all that apply. ☐ I have no known triggers

☐ Grasses	☐ High winds
☐ Weeds	☐ Looking at Sun
☐ Trees	☐ Heat
☐ Cat	☐ Cold
☐ Dog	☐ Cigarette smoke/wood smoke
☐ Dust	☐ Perfumes/colognes/hair sprays
☐ Dust mite	☐ Cleaning chemicals
☐ Mold/mildew	☐ Soaps and detergents
☐ Food-name	☐ Cigarette smoke/wood smoke

14. Which of the following do you have in your house? Check all that apply.

☐ Carpet	☐ Birds- how many	☐ Fake houseplants
☐ Tile	☐ Horses- how many	☐ Live houseplants
☐ Wood floor	☐ Smokers living in the house	☐ Stuffed animals in the bedroom
☐ Cats-how many	☐ Central air-conditioning	☐ Stuffed animals on the bed
☐ Dogs- how many	☐ Window air-conditioning	☐ Feather pillows/comforters
☐ Rabbits- how many	☐ Swamp cooler	☐ Grass outside
☐ Rats/ Mice- how many	☐ Recent water leaks in the house	☐ Trees outside
☐ Guniea Pigs/Hamsters-how many	☐ Presence of mold/mildew- Where?	☐ Green areas nearby

15. Do you have any <u>allergy to foods</u>? Answer the following please. ☐ I have none

Name of food you suspect allergy to	Nature of reaction	When

☐ Carry EpiPen	☐ Wear medic alert bracelet
☐ Member of food allergy anaphylaxis network	☐ Have food allergy action plan
☐ Food allergy evaluation by blood test done	☐ Food allergy evaluation by skin test done

16. Do you have any <u>allergy to medications</u>? Answer the following please. ☐ I have none

Name of the medication	Nature of reaction	When

17. Do you have any allergy to <u>bees, wasps, yellow jackets, hornets or fireants</u>? Answer the following. ☐ I have none

Type of insect sting (Bee, wasp, hornet etc.)	Nature of reaction	When

18. Are you allergic to <u>latex</u> (gloves, balloons, condoms, catheters, pacifiers, nipples etc.)? Answer the following. ☐ I have none

Type of material (gloves etc.)	Nature of reaction	When

19. Please tell us about your <u>social history</u>.

☐ **Student**	☐ Drinks alcohol frequently	☐ Not started menstruation yet
☐ Retired	☐ Used street drugs	☐ Attained menopause
☐ Homemaker	☐ Using Street drugs	☐ Had hysterectomy
☐ Unemployed	☐ **Have HIV**	
☐ Disabled	☐ Have/had sexually transmitted disease	**For children**
☐ **Current smoker**	☐ Sexually active	☐ Attends school
☐ Ex-smoker	☐ Using barrier protection	☐ Attends daycare
☐ Years smoked	☐ **Using birth control pill**	☐ Attends baby sitter
☐ Number of cigarettes/ day	☐ Using some other method of contraception	
☐ Year quit smoking	☐ Not pregnant	
☐ Do not drink alcohol	☐ Pregnant	
☐ Drinks alcohol socially	☐ Date of last menstrual period	

20. Please tell us about your <u>family medical history</u>. Check all that apply.

	Father	Mother	Sibling	Grandparents	Children	Aunts	Uncles	Cousins
Hay fever	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐	☐	☐
Swelling/ Angioedema	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐	☐	☐
Acid Reflux	☐	☐	☐	☐	☐	☐	☐	☐

Father	Mother	Sibling	Grandparents	Children	Aunts	Uncles	Cousins	Cousins
Allergy to bees/ wasps	☐	☐	☐	☐	☐	☐	☐	☐
Allergy to latex	☐	☐	☐	☐	☐	☐	☐	☐
Immunodeficiency	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Diseases	☐	☐	☐	☐	☐	☐	☐	☐
Leukemia/ Lymphoma	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐

21. <u>If you are a child under 18 years of age</u>, please tell us about your <u>birth history</u>.

☐ Born greater than 37 weeks gestation	☐ Delivery by C-section	☐ Was in NICU greater than 3 days
☐ Born less than 37 weeks gestation	☐ Required resuscitation at birth	☐ Breast fed
☐ Birth weight	☐ Was on a ventilator	☐ Bottle fed
☐ Normal Delivery	☐ Was in NICU less than 3 days	

22. Please tell us about <u>your immunization status.</u>

Children under 18 years	Adults
☐ Current on all recommended childhood immunizations	☐ Current on influenza vaccine for this season
☐ Not current on all recommended childhood immunizations	☐ Current on pneumococcal vaccine
☐ Current on influenza vaccine for this season	☐ Current on tetanus toxoid vaccine
	☐ Current on shingles vaccine

23. Please tell us if you suffer from any of the following <u>medical conditions.</u>

Medical Condition	Details
☐ Heart problem	
☐ High blood pressure	
☐ High cholesterol/triglyceride	
☐ Diabetes mellitus	
☐ Liver disease	
☐ Kidney disease	
☐ Thyroid problem	
☐ Stomach/intestinal problem	
☐ Female problem	
☐ Prostate problem	
☐ Cancer	
☐ Glaucoma	

Medical Condition	Details
☐ Cataracts	
☐ Osteoporosis/osteopenia	
☐ Arthritis	
☐ Autoimmune diseases	
☐ Blood diseases	
☐ Immunodeficiency	
☐ Sexually transmitted disease/ HIV	
☐ Other medical conditions	

24. Please list hospitalizations, E.R. visits and surgeries

E.R. Visits in the last 5 years	Hospitalizations in the last 10 years	Surgeries during your life

25. Anything Else You May Want Us to Know:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name of the patient **Patient/parent/Legal Guardian's signature** **Date**