CHESAPEAKE SPECIALTY CARE
CHESAPEAKE ENT
ALLERGY AUDIOLOGY

Allergy Testing Information

Patient name: _____ Appointment date/time: _____

Appointment location:

23 Crossroads Dr. Suite 400	410 Malcolm Dr. Suite E	5233 King Ave Suite 112
Owings Mills, MD	Westminster, MD	Rosedale, MD

Preparation for Your Allergy Testing

This test will take approximately 45 minutes. Please fill out the attached Consent Form and Allergy History Form and bring the completed forms to your appointment. Be aware that you may be asked to raise your shirt to expose your back depending on the type of test being performed, so please wear a loose-fitting shirt.

You must stop all antihistamine medications 7 days before allergy testing. A list of these medications is included below. Many over-the-counter cold and allergy medications also contain antihistamines, so please avoid these. **Over-the-counter sleep aids** and **motion sickness pills** must also be stopped 7 days prior to your testing. If you are uncertain if the medication you are taking contains an antihistamine, please check with our office or with a pharmacist. ***We reserve the right to charge a no show/cancellation fee for any appointment that is not rescheduled or cancelled 24 hours in advance***. If you need to cancel, please call 410-356-2626 option 1.

Over the Counter - ANY MEDICATION THAT SAYS "COLD" OR "ALLERGY" ON IT

Actifed Cold and Allergy	Claritin/Claritin D	Drixoral Cold and Allergy
Actifed Cold and Sinus	Dimetapp Cold and Allergy	Drixoral Cold & Flu
Allerfrim, Aprodine	Elixir	Motion sickness
Benadryl Allergy/Cold	Dimetapp Multi-Symptom Cold	Sleep aids
Benadryl –D Allergy/Sinus	& Allergy	Triaminic Cold & Allergy

Prescription Only

Accuhist	Codaprex	Rondec Syrup/DM/oral drops
Allegra/Allegra-D	Cyproheptadine (Periactin)	Rynatan, Ryantan-P
AlleRx	Deconamine	Semprex-D
Astelin	Deconamine ST, Chlordine SR	Tanafed
Astepro	Dimetane-DX	Train-C, Actifed with codeine
Azatadine	Extendryl	Tussionex
Atarax	Histussin HC	Tylenol PM
Advil PM	Phenergan/Dextromethorphan	Viravan
Biohist	Phenergan VC	Vistaril
Bromfenex	Phenergan VC with codeine	Xyzal
Chlorpheniramine	Poly-Histins	Zyrtec
Clarinex/Clarinex-D	Profen Forte	

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Patient Instruction/Consent Form for Allergy Skin Testing

Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected allergen into the skin using a very small needle and noting the development of a positive reaction. The results are interpreted 20 minutes after the application of the allergen. The skin test method used in our office is the prick method, also known as percutaneous. Prick tests are performed on your forearms or on your back.

You will be tested to important (location) airborne allergens, including trees, grasses, weeds, molds, dust mites, animal dander, and possibly some foods. The skin testing generally takes 45 minutes. If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and typically no treatment is necessary for this itchiness. Occasionally, local swelling at a test site will begin 4 to 8 hours after the skin tests are applied. These reactions are not serious and will disappear over the next week or so. They should be reported to your physician/physician assistant at your next visit.

After skin testing, you will consult with your physician/physician assistant who will make further recommendations regarding your treatment. Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

YOU MAY NOT TAKE THE FOLLOWING MEDICATIONS:

1. No prescription or over the counter oral antihistamines should be used **7 days** prior to scheduled skin testing. These include cold tablets, sinus tablets, hay fever medications, or oral treatments for itchy skin, over the counter allergy medications, such as Claritin, Zyrtec, Allegra, Actifed, Dimetapp, Benadryl, and many others. Prescription antihistamines such as Clarinex and Xyzal should also be stopped at least **7 days** prior to testing. If you have any questions whether or not you are using an antihistamine, please ask the physician/physician assistant and/or medical assistant. In some instances, a longer period of time off these medications may be necessary.
2. No nasal or eye antihistamine medications, such as Patanase, Pataday, Astepro, Optivar, or Astelin at least **7 days** before the testing. If you have any questions whether or not you are using an antihistamine, please ask the physician/physician assistant and/or medical assistant. In some instances, a longer period of time off these medications may be necessary.
3. No over the counter sleeping medications (e.g. Tylenol PM) and other prescribed drugs, such as amytriptyline hydrochloride (Elavil), hydroxyzine (Atarax), doxepin (Sinequan), and imipramine (Tofranil). Must be discontinued at least **2 weeks** (14 days) prior to your allergy test. Consult with your prescribing provider for more information.
4. Do not take medications for vertigo including meclizine and similar products containing Dramamine.
5. Please tell us if you are currently taking any blood pressure medications that have a beta-blocker.

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YOU MAY

1. You may continue to use your intranasal allergy sprays such as Flonase, Rhinocort, Nasonex, Nasacort, Omnaris, Veramyst and Nasarel.
2. Asthma inhalers (inhaled steroids and bronchodilators), leukotriene antagonists (e.g. Singulair, Accolate) and oral theophylline (Theo-Dur,T-Phyl, Uniphyl, Theo-24, etc.) should be used as prescribed.
3. Most drugs do not interfere with skin testing, but make certain that your physician/physician assistant and medical assistant know about every drug you are taking (bring a list if necessary).

Skin testing will be administered at this medical facility with a physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the provider and/or medical assistant know if you are pregnant and/or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reaction to the allergy testing. Beta-blockers may make the treatment of any reaction to skin testing more difficult. **Please note that these reactions rarely occur, but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.**

We request that you do not bring small children with you when you are scheduled for skin testing, unless they are accompanied by another adult who can sit with them in the waiting room.

If for any reason you need to change your skin test appointment, please give us at least 48 hours notice. Due to the length of time scheduled for skin testing, a last minute change results in a loss of valuable time that another patient might have utilized. If you cancel or reschedule your appointment with less than 24 hours notice, you will be charged a $25 fee. Please call 410-356-2626 option 1.

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

_____ _____

Printed Patient Name Date of Birth

_____ _____

Patient Signature Date Signed

If patient is a minor, a parent or legal guardian must accompany the child throughout the entire procedure and visit.

_____ _____

Parent or Legal Guardian* Date Signed

Please complete next page.

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Allergy History Form

Patient Name: _____ DOB: _____ Date: _____

Please put a check next to each symptom. ***Current*** = the past 90 days ***Past*** = 91 days or older even if long ago ***Never***

EARS	Current	Past	Never
Hearing loss	☐	☐	☐
Deafness	☐	☐	☐
Ringing	☐	☐	☐
Discharge	☐	☐	☐
Earache	☐	☐	☐

NOSE	Current	Past	Never
Decreased smell	☐	☐	☐
Bleeding	☐	☐	☐
Pain	☐	☐	☐
Obstruction	☐	☐	☐
Seasonal allergies	☐	☐	☐
Chronic sinusitis	☐	☐	☐
Frequent sneezing	☐	☐	☐

THROAT	Current	Past	Never
Frequent soreness	☐	☐	☐
Bad tonsils	☐	☐	☐
Pain	☐	☐	☐
Infections	☐	☐	☐

HEAD/EYES	Current	Past	Never
Headaches	☐	☐	☐
Burning itching eyes	☐	☐	☐
Red/watery eyes	☐	☐	☐
Sinus pain/pressure	☐	☐	☐
Sinus infections	☐	☐	☐

MOUTH	Current	Past	Never
Bad breath	☐	☐	☐
Bleeding gums	☐	☐	☐
Sores/ulcers/blisters	☐	☐	☐
Dry mouth	☐	☐	☐
Loss of taste	☐	☐	☐

SKIN	Current	Past	Never
Irritation	☐	☐	☐
Rash/hives	☐	☐	☐
Sores	☐	☐	☐
Gout	☐	☐	☐
Shingles	☐	☐	☐
Psoriasis	☐	☐	☐

PAIN	Current	Past	Never
Muscle weakness/pain	☐	☐	☐
Joint pain	☐	☐	☐
Tendonitis/bursitis	☐	☐	☐
Back/disc pain	☐	☐	☐
Neck pain	☐	☐	☐
Neuropathy	☐	☐	☐
Sciatica	☐	☐	☐
Fibromyalgia	☐	☐	☐

PSYCHIATRIC	Current	Past	Never
Depression	☐	☐	☐
Anxiety	☐	☐	☐
Insomnia	☐	☐	☐

NEUROLOGICAL	Current	Past	Never
Dizziness	☐	☐	☐
Fainting	☐	☐	☐

GENERAL	Current	Past	Never
Chronic fatigue	☐	☐	☐
Frequent fevers	☐	☐	☐
Frequent chills	☐	☐	☐
Cold/flu	☐	☐	☐
Chronically sick	☐	☐	☐
Night sweats	☐	☐	☐
High blood pressure	☐	☐	☐
Chronic use OTC/Rx drugs	☐	☐	☐
Swelling in face, ankles, fingers	☐	☐	☐

ENDOCRINE	Current	Past	Never
Weight loss/gain	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid disease	☐	☐	☐
Hot flashes	☐	☐	☐

RESPIRATORY	Current	Past	Never
Shortness of breath	☐	☐	☐
Wheezing	☐	☐	☐
Chest congestion	☐	☐	☐
Bronchitis	☐	☐	☐

GASTROINTESTINAL	Current	Past	Never
Intestinal disease	☐	☐	☐
Stomach sensitivities	☐	☐	☐

- During which months do the symptoms checked above occur? ☐ All ☐ Jan ☐ Feb ☐ Mar ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec
- When are symptoms worse? ☐ Morning ☐ Afternoon ☐ At home ☐ At work/school ☐ Other location: _____
- Do these symptoms interfere with your daily activities? ☐ Severely ☐ Moderately ☐ Mildly
- Are your symptoms ☐ Constant ☐ Come and go
- Family history ☐ Asthma ☐ Colitis ☐ Eczema ☐ Hay fever ☐ Migraines ☐ Ulcers ☐ Nervous disorders ☐ Sinus issues
- Do you suffer from ☐ Bee sting allergy ☐ Food allergy ☐ Drug allergy: _____
- Are the symptoms above made worse by: ☐ A/C ☐ Cosmetics ☐ Damp areas ☐ Dust ☐ Pollution ☐ Travel ☐ Soap ☐ Mowing lawns ☐ Plants/grasses/trees ☐ Perfumes/Fragrances ☐ Smoke ☐ Wind ☐ Wool ☐ Weather (wet, dry, hot, cold, changes)
- Do you have pets or are you exposed to other animals? ☐ Cats ☐ Dogs ☐ Other: _____
- Have you ever been treated with allergy shots? ☐ Yes ☐ No If yes, did the shots help you? ☐ Yes ☐ No
- Are you currently taking any medicine for allergy symptoms? ☐ No ☐ Yes: _____
- Potential contraindications
    1. Do you have uncontrolled asthma? ☐ Yes ☐ No
    2. Do you have a history of anaphylaxis? ☐ Yes ☐ No
    3. Do you have cancer? ☐ Yes ☐ No

Office use only: AT: ☐ Yes ☐ No
Notes: