Advantage Allergy Services

ALLERGY HISTORY

Patient Name: DOB Date:

Physician: Pat ID:

1. During which months do symptoms occur?

☐ All months

☐ January	☐ April	☐ July	☐ October
☐ February	☐ May	☐ August	☐ November
☐ March	☐ June	☐ September	☐ December

2. Are symptoms worse?

☐ Morning	☐ Afternoon	☐ Evening	☐ Night
☐ At home	☐ At work/school	☐ Other (location):	

3. Are symptoms:

☐ Constant ☐ Erratic ☐ Rare

4. Do symptoms interfere with your activities?

☐ Not at all ☐ A little ☐ Moderately ☐ All the time

5. Family History

☐ Asthma	☐ Eczema	☐ Sinus problems	☐ Migraine
☐ Hay Fever	☐ Ulcer	☐ Nervous disorder	☐ Colitis
☐ Other:			

6. Your medical conditions:

☐ High blood pressure	☐ Heart disease	☐ Asthma	☐ Bronchitis
☐ Bee sting allergy	☐ Thyroid disease	☐ Emphysema	☐ Diabetes
☐ Hormonal difficulty	☐ Stomach or intestinal problems/disease		

☐ Drug allergy (specify):

☐ Food allergy (specify):

7. Do any of the following cause or make your symptoms worse?

- [ ] Milk/milk products
- [ ] Fruit or juices
- [ ] Vegetables
- [ ] Eggs/egg products
- [ ] Beer
- [ ] Wine
- [ ] Wheat products
- [ ] Liquors
- [ ] Nuts/beans/seeds
- [ ] Cheese
- [ ] Meat
- [ ] Mushrooms
- [ ] Vinegar
- [ ] Chicken
- [ ] Poultry
- [ ] Fish
- [ ] Other:
- [ ] Other:
- [ ] Other:
- [ ] Other:

8. Are your symptoms made worse by:

- [ ] Wind
- [ ] Smoke
- [ ] Barns/hay
- [ ] High pollution day
- [ ] Damp areas
- [ ] Soap
- [ ] Powder
- [ ] Mowing lawns
- [ ] Insecticides
- [ ] Dust
- [ ] Paint fumes
- [ ] Perfumes
- [ ] Cosmetics
- [ ] Newspapers
- [ ] Wool
- [ ] House plants
- [ ] Weather change
- [ ] Wet weather
- [ ] Dry weather
- [ ] Hot day
- [ ] Cold day
- [ ] Air-conditioning
- [ ] Travel/vacations
- [ ] Indoors (explain):
- [ ] Outdoors (explain):

9. Do you have pets or are you exposed to other animals?

- [ ] Cats
- [ ] Dogs
- [ ] Other (list):

PREVIOUS ALLERGY TREATMENT

1. Have you ever been tested for allergies?

- [ ] Yes
- [ ] No
- [ ] Within the last year?

2. Have you ever been treated with Allergy Shots?

- [ ] Yes
- [ ] No
- [ ] Within the last year?

3. If you had Allergy Shots previously, what were you treated for?

- [ ] Grass pollens
- [ ] Molds
- [ ] Weed pollens
- [ ] Tree pollens
- [ ] Animals
- [ ] Dust

4. Did the Allergy Shots help you?

- [ ] Yes
- [ ] No
- [ ] Don't know

What years were the shots taken?

to

ALLERGY TEST PRESCREEN

1. Are you on any blood pressure medication? ☐ Yes ☐ No
2. Are you on any heart medication? ☐ Yes ☐ No
3. Have you ever had a stroke? ☐ Yes ☐ No
4. Have you ever been diagnosed with, or do you have a history of cardiovascular disease? ☐ Yes ☐ No
5. Have you ever had a severe anaphylactic reaction (severe allergic reaction) that required medical attention? ☐ Yes ☐ No
6. Are you a moderate / severe asthmatic? ☐ Yes ☐ No
7. Within the past year have you had an allergy scratch test? ☐ Yes ☐ No
8. Are you pregnant? ☐ Yes ☐ No

If there is a possibility you are pregnant, please notify the physician before you have the allergy test.

☐ Yes ☐ No

Patient Signature: Date:

Physician Notes:

Physician Signature: Date:

Advantage
Allergy Services

Informed Consent for Allergy Testing and Immunotherapy Treatment

Please read carefully and ask questions on concerns before signing!

The purpose of this consent form is to provide educated consent information as well as a clear understanding of the risks of testing for allergies, and the requirements and risks associated in treating allergies with Immunotherapy :

1. This **consent form** and an **allergy history and prescreen** must be completed prior to testing you, the patient ,for allergies using the **patient skin test record.** Your physician has diagnosed Allergic Rhinitis and an allergy test will show your reactions and severity to local environmental allergens that may affect your daily life.

2. **Possible Risks**: It is impossible to truly list all of the complications that may occur from any procedure. However, risks here have been carefully considered. There may be possible risks involved in these procedures including, but not limited to:

- **Local Reactions:** Burning, itching, bleeding, swelling and/or hives, redness of skin, skin blistering/sloughing, and/or possible infection at the injection/puncture site. **Initials: ______**
- **Mild Systemic Reactions:** Nasal congestions and/or "runny nose", skin rash, diarrhea, headache, itching of ears, nose, throat and/or sneezing occurring within two hours of the injection/puncture and/or itchy, watery or red eyes. **Initials: ______**
- **More severe reactions:** Wheezing, coughing, or shortness of breath; bronchial asthma, generalized hives (welts); swelling of tissue around the eyes, tongue or throat; stomach or uterine (menstrual-type) cramps, possible miscarriage (if pregnant). **Initials : ______**
- **Rare complications:** Abnormalities of the heart beat, delayed response, loss of ability to maintain blood pressure and pulse, anaphylactic shock, death. **Initials : ______**
- **Severe:** There is the possibility of severe reaction involving the heart, lungs and blood vessels which, if unrecognized and untreated, could be **fatal.** **Initials: ______**

3. **Safety Precautions:** Allergy treatment guidelines state that the majority of reactions from allergy testing and/or Immunotherapy which require emergency treatment occur within the first 20 minutes of an injection. As a safety precaution and using standard guidelines: **all patients who receive an allergy test or immunotherapy injections must remain in our designated waiting area for no less than 20 minutes (30 minutes for severe reaction) or until checked by the clinic medical staff or allergy technician.** If you choose to leave prior to the 20 minute waiting time after your injection, you do so against medical advice and therefore accept all responsibility and liability for any subsequent reaction(s) from your allergy shot(s).

4. **Duration of Immunotherapy Treatment**: The average patient will be on allergy immunotherapy for a minimum of two (2) years. The total duration of therapy is impossible to predict and is dependent on each individual patient's reaction and severity to allergens. Your treatment with Immunotherapy will be more successful and pose less risk if you consistently receive your shots in clinic on schedule or administer at home according to your dosage log, which will be communicated and reviewed by your physician and allergy technician.

   Note: If you are not consistent in arriving at the appointed time(s) for your allergy shots, you not only decrease the success of your treatment but also increase your risk of having adverse reaction(s) to your immunotherapy, including the risk of anaphylactic shock. If you cannot be consistent in arriving at the appointed time(s) for your allergy shots, you will be asked, for your own protection, to consider alternative forms of allergy treatment. Once home administer patients complete their requirements for out of clinic treatment, the same rules apply for self-administering. Since the physician still needs to monitor the patient progress and safety, follow up communications with your allergy technician need to occur and resolution to any problems must be addressed in a timely manner. Our allergy technician provides this critical requirement

for supervision of health care outside of the clinic to continue home administration. In this Consent Form you are agreeing to keep the communications open and provide feedback and proof of continued use of Immunotherapy treatments. **A patient who is unable to maintain their injection schedule may be prevented from receiving allergy shots and their treatment may be discontinued at the discretion of the physician.**

5. **In-Office Administration**: The preferred location for administration of allergen immunotherapy is in the office of the physician who prepared the patient's allergen immunotherapy extracts. Your physician employs an allergy technician trained to educate, test, compound therapy, and administer injections as well as continue tracking your follow up treatment progress. Your allergy technician has a shot clinic setup in office during normal business hours for your convenience. This shot clinic will allow you to quickly receive your injections at scheduled time so that you are less inconvenienced by not having to wait in the patient waiting room with other clinic patients. Our allergy technician will have the necessary injection and materials to quickly take care of your needs.

6. **At-Home Administration:** This method is not preferred by governing agencies of Allergists. However, due to guidelines that state what is required if the physician allows patients to at-home administer, you the patient must consent to follow these critical guidelines. Very careful consideration of potential benefits and risks of at-home administration of allergen immunotherapy should be made on an individual patient basis. If this approach is used, informed consent must be signed, and the person administering the injections to the patient whether self or parent/guardian must be educated about how to use administer immunotherapy and recognize and treat anaphylaxis.

7. If the patient receiving this immunotherapy, whether in-office or at-home administration, transfers to another physician, a decision to continue this therapy must be made by the new physician.

8. If you, the patient, do transfer to a new physician and continue immunotherapy, minimized risk of systemic reaction will occur. All allergy records should be transferred to your new physician.

Acknowledgement

I understand that the physician, medical personnel or other assistant will rely on statements about the patient's medical history, allergy history and prescreen and other information in determining whether to perform the procedures or the course of treatment for the patient's condition in recommending the procedures.

I understand that during the course of the procedures described above it may be necessary or appropriate to perform additional procedures, which are unforeseen, or not known to be needed at the time this consent is given. I consent to and authorize the person described herein to make the decision concerning such procedures, and consent to and authorize the performance of such additional procedures, if/when they are deemed necessary or appropriate.

By signing this form, I acknowledge that I have read or had this form explained to me and that I fully understand its contents. I have been given the opportunity to ask questions and all my questions have been answered satisfactorily. I consent to have allergy testing administered to me, under the supervision of my physician, and wish to have my results interpreted by my physician and all instruction carried out by his appointed allergy technician.

______________________	______________	______________
Patient/Guardian	**Date**	**Patient ID**
______________________	______________	______________
Allergy Technician	**Date**	**Patient DOB**

Advantage Allergy Services

INSTRUCTIONS FOR ALLERGY TESTING

Your symptoms and findings on your physical examination suggest that you may have an allergy disorder. A wide variety of substances in the environment including pollens, molds, and animal dander may be contributing to your problem. The purpose of skin testing is to identify those substances to which your body has become sensitized. The benefits and risks have been explained in detail to you.

The multi-test skin test will be used. This test takes two minutes to apply to your skin and fifteen minutes to wait for a proper reading of your reaction to allergens. This test will be administered on the arms of normal-sized adults and only given to children and small-statured adults on their backs due to limited surface area for testing. A positive response will appear as redness and local swelling similar to a mosquito bite.

Please arrive fifteen minutes early for scheduled appointments and realize if you are a walk-in patient that you must fill out paperwork and ensure that certain medications were not taken prior to testing. Otherwise, an appointment must be made for a later testing time after criteria have been met, such as a short period off of certain medications. An allergy history and prescreen form is mandatory for testing, and will need to accompany you prior to testing. Local reactions to the test will disappear from testing site after a few hours at most.

PRIOR TO ALLERGY TESTING

PLEASE STOP ANY MEDICATION CIRCLED IN THE SECOND PAGE OF THIS FORM!

You may continue taking other medications prescribed through this office (nasal sprays and asthma medications) that are not on this list prior to testing.

If you are particularly bothered by nasal congestion during this waiting period, plain over the counter Sudafed (not Sudafed Plus) may be taken. Please call the office if you have any other questions about particular medications.

It is **EXTREMELY IMPORTANT** that you notify your physician if you are taking any Beta Blockers used for heart disease or hypertension, or Tricyclin anti-depressants for pain or depression.

Follow a normal diet on the day of testing. You may plan normal activities following the testing. It is not unusual for local test site swelling to persist for those with high sensitivity for 24 to 36 hours after testing. Cool compresses will help reduce discomfort.

This information is designed to lower your risk to anaphylaxis shock and side effects, not to scare you into anxiety. All precautions for your safety are being met by informing you the patient, asking questions on your history and prescreen, and relying on your adherence to restricting certain medications prior to testing. Almost all patients receive testing with little or no side effects, and with the small inconveniences of preparation, you the patient will soon know exactly what allergies are affecting your day-to-day life.

Thank you for your patience and compliance.

Patient/Guardian ______________ **Date** ______________ **Patient ID** ______________

Patient DOB ______________

PLEASE DISCONTINUE USE OF THESE MEDICATIONS FOR TIMES LISTED BELOW

2 Days Prior

ASTELIN
ASTERPRO
ATENOLOL
BENADRYL
BEPREVE
BETAGAN
BETAPACE
COREG
CORGARD
CARVEDIOLOL
DIPHENHYDROMINE
ELESTAT
INDERAL
LABETALOL
LOPRESSOR
METOPROLOL
OCUPRESS
OPTIVAR
PATADAY
PATANASE
PROPRANALOL
SOTALOL
TENORMIN
TIMOLOL
TIMOPTIC
TOPROL XL
TRANDATE
ZEBETA
ZIAC

ACTIFED
ALAVERT
ALKA-SELTZER COLD FLU
ALLEGRA
ATARAX
BROMFED
CETRIZINE
CHLORPHENIRAMINE
CHLORTRIMETON
CIMETIDINE
CYPROHEPTADINE
DRISTAN
DIMETAPP
EXTENDRYL
FAMITIDINE
FEXOFENADINE
HYDROXYZINE
NYQUIL
PEPCID
PERIACTIN
PHENERGAN
PROMETHAZINE
RANITIDINE
RYNATAN
TAGAMET
TAVIST
THERA-FLU
TYLENOL PM
VISTARIL
WAL-ZYR
XYZAL
ZANTAC
ZYRTEC

ALLERCLEAR
AMITRIPTLYNE
CLARINEX
CLARITIN
DOXEPIN
ELAVIL
IMIPRAMINE
LORATADINE
NORTRIPTYLINE
WALITIN

5 Days Prior

7 Days Prior