

*****READ IMMEDIATELY*****
INSTRUCTIONS

for a successful appointment

1. **REMEMBER NOT TO USE** the following products for **THREE** days prior to your scheduled testing date:
*Antihistamines, decongestants, over-the-counter cold remedies, steroids, cortisone, medications for asthma, and vitamin C (unless specifically okayed by the doctor)
2. **WEAR** a short sleeve shirt or T-shirt.
3. **REMEMBER NOT TO WEAR** lotions, perfume, cologne, hair spray, scented body powder or aftershave lotion on the day of testing.
4. **AVOID** mouthwash, breath fresheners and chewing gum on the day of testing
5. **CLEAN** the arm between your shoulder and elbow thoroughly. This area will be tested with intradermal injections.
6. **PLEASE COMPLETE** the attached questionnaire and bring it to your appointment. This packet gives us information to better service you.

Skin testing is done on the outer surface of the upper arm between the shoulder and the elbow. The above instructions are important because these things may interfere with obtaining proper reactions.

There is no eating allowed during the testing. However, it is a good idea to eat something before coming to your appointment. The only beverage you may have during testing is water.

There are two mandatory skin tests that must be performed before the allergy testing may begin. These two are called Histamine and Glycerin. These will be defined and explained by your allergy technician.

Unless another doctor is referring you, it will be necessary to make an appointment with our attending physician if you would like us to bill your insurance. Please bring a copy of your insurance card with you and verify in advance that your insurance covers the skin testing and vaccines. If your insurance does not pay within 60 days, you are responsible to bring your account current.

Your appointment is scheduled for two hours and some material are prepared in advance, so it is very important that you call 24 hours in advance if you cannot keep this appointment.

Thank you very much and we look forward to seeing you at your appointment!

Date: _____
 Name: _____ Age: _____ Sex _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Occupation: _____ Referred By: _____
 Employer: _____
 Work #: _____ Home #: _____ Cell #: _____
 Person Responsible for Account: _____
 Driver's License #: _____ SS #: _____
 Insurance Co.: _____

- *Answer every question you can
- *Circle YES or NO to describe your feelings most accurately
- *If any symptom occurred more than a year ago but has not reoccurred in the last year, write "P" before YES/NO.
- *You are encouraged to expand or modify your answers by writing notes or comments in the margins of each page.

I. What do you feel to be your most troublesome, uncomfortable symptom(s). Explain:

II. SEASONAL INCIDENCE: Is your condition worse:

YES	NO	In the spring?	YES	NO	In the summer?
YES	NO	In the winter?	YES	NO	In the fall?
		YES	NO	Same all year?	

III. HISTORY OF ONSET: How long have you suffered from the above symptoms? _____

YES	NO	Did your symptoms begin gradually?
YES	NO	Did your symptoms begin suddenly?

IV. AS A CHILD:

YES	NO	Did you wet the bed?
YES	NO	Did you have colic?
YES	NO	Did you have croup?
YES	NO	Did you have frequent bronchitis or chest colds?
YES	NO	Did you have hay fever?

- YES NO Were you treated by an allergist?
- YES NO Did you have frequent attacks of diarrhea?
- YES NO Did you have dark circles under your eyes?
- YES NO Did you perform poorly in school?
- YES NO Did you have problems concentrating in school?
- YES NO Did you have learning disabilities?
- YES NO Were you a hyperactive, restless child
- YES NO Did you have a chronic stuffy or runny nose
- YES NO Did you have so-called growing pains?
- YES NO Did you have asthma?
- YES NO Did you have a history of epilepsy or seizures?
- YES NO Did you have a pale face?
- YES NO Did you have frequent headaches as a child?
- YES NO Did you have mood swings?
- YES NO Did you have behavior problems not under your control?

V. NOSE SYMPTOMS:

- YES NO Does the inside of your nose often itch?
- YES NO Do you have attacks of sneezing?
- YES NO Does the sneezing occur especially in the morning?
- YES NO Does your nose block up?
- YES NO Do you have a runny nose?
- YES NO Do you have headaches when your nose blocks up/
- YES NO Are you bothered with excessive mucus dripping from the back of your nose into your throat? (post-nasal drip)
- YES NO Do you have hay fever?

VI. THROAT SYMPTOMS:

- YES NO Do you cough or clear your throat frequently?
- YES NO Do you often have sore throats?
- YES NO Do you have sinus problems?
- YES NO Do your lips swell at times?
- YES NO Do you get hoarseness at times even though you don't have a cold?
- YES NO Does your tongue feel swollen, sore, or become red at times?

VII. EAR SYMPTOMS

- YES NO Are you bothered by excessive itching in your ears?
- YES NO Are you bothered with attacks of hearing loss which later clears up?
- YES NO Do you have attacks of dizziness or light-headedness?
- YES NO Do you have ringing, popping or buzzing in your ears from time to time?
- YES NO Do you have chronic drainage from your ears?
- YES NO Do you have frequent ear infections?

VIII. EYE SYMPTOMS:

- YES NO Do you have blurring of your vision?
- YES NO Are you bothered with itching of the eyes?
- YES NO Do your eyes water excessively at times?
- YES NO Does the skin of your eyelids become red and swollen?
- YES NO Do you get eczema on your eyelids?
- YES NO Do your eyes sometimes have a thick ropy secretion which causes the lids to stick together in the morning?

IX. CHEST & HEART SYMPTOMS:

- YES NO Do you have heart palpitations?
- YES NO Do you have skipped beats?
- YES NO Do you have frequent chest pains, pain in the front of your heart?
- YES NO Does your heart ever beat rapidly or pound in your chest for not apparent reason?
- YES NO Do you have frequent wheezing cough?
- YES NO Do you have frequent bouts of shortness of breath?
- YES NO Do you have asthma?
- YES NO Do you have frequent attacks of bronchitis?
- YES NO Do you smoke cigarettes? For how long? _____
How many per day? _____

X. GASTROINTESTINAL SYMPTOMS:

- YES NO Do you have attacks of diarrhea?
- YES NO Is there ever blood or mucus in your stool?
- YES NO Do you suffer with cramping pains in your abdomen?
- YES NO Do you pass excessive amounts of gas (flatulence)?
- YES NO Do you frequently belch after eating?
- YES NO Do you have indigestion or heartburn after eating?
- YES NO Do you bloat after meals?
- YES NO Do you have bouts of nausea or vomiting after eating?
- YES NO Do you suffer from chronic constipation?
- YES NO Have you ever had a history of ulcers
- YES NO Have you had gastritis?
- YES NO Do you have a "celiac sprue"?
- YES NO Do you have ulcerative colitis?
- YES NO Do you have regional enteritis?
- YES NO Have you ever been told you have a mucus colitis, irritable colon, or spastic colon?
- YES NO Have you ever had acute pain in the abdomen associated with hives or itching skin?
- YES NO Are there any foods or drugs that you feel disagree with you each time you consume them? If yes, please list them: _____

XI. MUSCULOSKELETAL SYMPTOMS:

- YES NO Do you tend to get tired, physically weak, or fatigued easily or more often than others?
- YES NO Do you have muscle pains or aches?
- YES NO Do you have joint pains or aches?
- YES NO Do you have joint swelling?
- YES NO Do you have joint stiffness?
- YES NO Do you have joint redness?
- YES NO Do you have soreness?
- YES NO Do you have backaches?
- YES NO Do you have chest pins for no apparent reason?
- YES NO Do you have neck muscle spasms?
- YES NO Do you have shoulder muscle spasms?
- YES NO Do you have limitations of motion in your joints?
- YES NO Do you have rheumatoid arthritis?

XII. SKIN SYMPTOMS:

- YES NO Do you suffer from acne?
- YES NO Do you suffer from eczema?
- YES NO Do you suffer from allergic dermatitis?
- YES NO Do you sometimes suffer from hives?
- YES NO Are you bothered with itching of the skin?
- YES NO Are you bothered by flushing of hot flashes?
- YES NO Do you get swelling of certain parts of the skin for no apparent reason?
- YES NO Is your skin, especially your face, somewhat pale?
- YES NO Do you have dark circles under your eyes?
- YES NO Do you have “bags” or swelling under your eyes?
- YES NO Do you perspire excessively?
- YES NO Does contact of your skin with certain plants, animals or chemicals cause a rash?

XIII. MENTAL & PSYCHOLOGICAL SYMPTOMS:

- YES NO Are there times when you feel mentally slow, sluggish or lethargic?
- YES NO Does your head often feel full or “enlarged”?
- YES NO Do you become irritable or annoyed for no apparent reason?
- YES NO Do you have periods of anxiety or nervousness for no apparent reason?
- YES NO Have you been told that you are a restless hyperactive person?
- YES NO Do you have recurring periods of depression?
- YES NO Are your depressions worse or more prevalent in the mornings when you wake up?
- YES NO Do you have unexplained periods when you have difficulties speaking or when you stammer or stutter?
- YES NO Do you often have “crying jags” for no apparent reason?

- YES NO Do you have poor memory at times?
- YES NO Do you sometimes become easily confused for no apparent reason?
- YES NO Have you even been told you have a learning disability?
- YES NO Do you have a frequent tendency to misread something?
- YES NO Do you ever have amnesia for words, numbers, or names?
- YES NO Do you find yourself staring or daydreaming excessively?
- YES NO Have you ever hallucinated?

XIV. MISCELLANEOUS ALLERGY QUESTIONS:

- YES NO Do you get drowsy or sleepy after eating?
 - YES NO Do you have frequent headaches?
 - YES NO Do you have migraine headaches?
 - YES NO (For men only) Do you have problems with frequent or painful urinations or difficulty starting your stream?
 - YES NO (For women only) Do you have problems with vaginal itching or discharge?
 - YES NO Have you even been treated or tested for allergies before? Please specify date of treatment, type of treatment, and name of allergist. _____
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XV. INHALANT ALLERGIES: DO you notice that your symptoms begin or are made worse:

- YES NO When your house is being swept or cleaned?
- YES NO When the rugs or carpets are being beaten?
- YES NO When the bed is being made?
- YES NO During spring house cleaning?
- YES NO When the heat is turned on at the first cold in the winter?
- YES NO In rooms such as libraries or bedrooms where dust is noticed?
- YES NO When lying on a feather pillow?
- YES NO When fluffing pillows?
- YES NO When using a down comforter?
- YES NO When you are near live chickens, ducks, pigeons, canaries or other birds?
- YES NO When you are around anyone who handles poultry or fowl?
- YES NO When you are around any of the following animals: dogs, cats, horses, goats, rabbits, cows, hogs, or sheep?
- YES NO When you handle the following: furs, rugs, certain articles of clothing, dress goods, blankets, gloves, hats brushes, or toy animals?
- YES NO When using scented face, talcum, body, bath or foot powder?
- YES NO IN beauty salons or barber shops?
- YES NO When you are around people who use a lot of perfume or powder?
- YES NO When you smoke?
- YES NO When you are around those who are smoking?

- YES NO When in nightclubs or other smoky place?
 YES NO When you are exposed to household insect powder or sprays?
 YES NO When you are exposed to dusting powder, liquids or sprays used in the home or garden?
 YES NO Do you suspect any food or chemical of causing or aggravating your condition? Please specify: _____

XVI. FOOD AND ALCOHOL:

- YES NO Do you or did you go on eating binges?
 YES NO Are there any foods you crave, love or overindulge in? Please list: _____

 YES NO Are you on any type of special diet? Please explain: _____

 YES NO Are you uncomfortable or ill if you do not eat on time?
 YES NO Do you have a distinct feeling of well being after you eat?
 YES NO Are you more alert or energetic after eating?
 YES NO Do you feel better if you skip a meal or two or go on a fast?
 YES NO Does fasting relieve many of your symptoms?
 YES NO Does fasting make you uncomfortable or sick?
 YES NO Do you feel good after a three to five day fast?
 YES NO Do alcoholic beverages make you ill?
 YES NO Do alcoholic beverages make your symptoms go away?
 YES NO Do you get hangover symptoms from one or two drinks?
 YES NO Do you get "tipsy" or drunk on less than two drinks?

XVII. FOCAL INFECTION HISTORY:

- YES NO Are you conscious of a foul odor in your nose?
 YES NO Do you have a dripping from the back of your nose which has a "sickening sweet" taste or is green or yellow?
 YES NO Have you even been treated for sinus trouble?
 YES NO Do you have any bad teeth?
 YES NO Do you have noticeable bad breath?
 YES NO Do your gums bleed?
 YES NO Do your ears drain?
 YES NO Do you have increased frequency of urination?
 YES NO Does urination cause a burning sensation?
 YES NO Do you have pus in your urine?
 YES NO Do you have genital discharge?
 YES NO As far as your know, do you have any infection in any part of your body?
 YES NO (For men only) Have you even been told you have an infection of the prostate gland?

XVIII. GENERAL NUTRITIONAL HISTORY:

YES NO Are you following any particular nutritional program?
Explain. _____

YES NO Are you taking any vitamin or mineral supplements with your
meals? _____

YES NO Do you take these or other dietary supplements regularly?

YES NO Have you noticed any benefits since beginning your diet
supplements? Please specify? _____

YES NO Are you overweight? What is your current weight? What is your
preferred weight?

YES NO Do you have any additional information you would like your
doctor to know?