Allergy Neutralization/Provocation New Patient Packet

READ IMMEDIATELY
INSTRUCTIONS FOR A SUCCESSFUL APPOINTMENT

* **INHALANT SKIN TESTING** (Tree, weed, grass, cats, dogs, dust mite, house dust, mold, etc.) takes approximately 1 to 1 ½ hours

***FOOD/CHEMICAL TESTING** takes approximately 2 hours per session.

Note: There are two mandatory skin testing that must be performed before the allergy testing may begin. There two items are Glycerin and Histamine. These will be defined and explained by you allergy technician.

DO NOT wear perfumes, colognes, lotions, scented hair sprays, scented powder, or aftershave etc., into the office. This also applies to parents, family members, friends, etc. that accompany the patient. Due to limited space in our testing area we can only allow one parent per child.

DO NOT take Claritan, Clarinex, Zyrtec, Allegra, Astelin nasal spray or any other prescription or over the counter antihistamine, decongestants, tranquilizers, steroids, cortisone, sleeping pills, asthma medicines, or more the 1000 mg. of vitamin C for **72 hours before testing**. If you are on maintenance tranquilizers or antidepressants consult your provider prior to testing. **If you have any questions regarding any medication that you are taking that might interfere with your testing, please check with your provider or the allergy department prior to your testing appointment.**

DO NOT restrict your diet; if scheduled for food testing….***eat foods to be tested within 24 hours of the testing session.***

PATIENTS under the age of 18 must have a parent or guardian with them.

WEAR a short sleeved shirt of t-shirt. Skin testing is down 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 reaction.

There is no eating or drinking (except water) allowed during testing. IT is a good idea to eat before coming to your appointment.

Unless another provider is referring you, it will be necessary to make an appointment with our physician if you would like 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 for charges on your account.

NO SHOWS: We request that you call at least 24 hours prior to your scheduled test time if you need to cancel or reschedule your appointment as we have reserved this time for your test. Avante Medical Center reserves the right you charge a no-show fee if the appointment is not kept.

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SYMPTOM CHECKLIST

Name ___________________________ Age: ___________ Date _____________

PLEASE READ EACH QUESTION CAREFULLY
Then circle Yes or No to indicate your answer. If yes-please explain.

I. SEASONAL INCIDENCE: Is your condition worse:
In the Spring? YES NO In the Summer? YES NO
In the Winter? YES NO In the Fall? YES NO Same all year? YES NO

II. HISTORY OF ONSET: How long have you suffered from the above symptoms? ______________________
Did your symptoms begin gradually? YES NO Did your symptoms begin suddenly? YES NO

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

Yes No Do you have postnasal drip?

Yes No Do you have nasal congestion?

Yes No Do you have recurrent sinus infections?

Yes No Do you have asthma or wheezing?

Yes No Are your symptoms worse indoors or outdoors? Circle which

Yes No Do your symptoms increase with the return of cold weather?

Yes No Do you have irritation or itching of the eyes?

Yes No Are your symptoms worse while dusting or sweeping?

Yes No Are your symptoms worse on humid evenings?

Yes No Are your symptoms seasonal?

Yes No Are your symptoms worse in basements?

Yes No Are your symptoms worse in barns?

Yes No Are your symptoms worse in certain homes?

Yes No Do you react to animals?

Yes No Are there any foods or beverages that you a) crave or b) eat frequently? a)______________ b)_______________ c)_______________ d) ________________

Yes No Are there any foods or beverages that you dislike? List:

Yes No Are you awakened between the hours of 1:00 a.m. and 5:00 a.m. with the following symptoms? Headache, dizziness, stomach cramps, bloating, or dry cough? (Circle which)

Yes No Do you or any member of your family have hay fever, asthma, hives, chronic skin condition, migraine headaches or colitis? (Circle which)

Yes No During childhood did you have any of the following: Eczema, hay fever, asthma, and food feeding problems? (Circle which)

Yes No Do you ever have itching of the skin, palate or roof of your mouth or skin rash? (Circle which)

Yes No Do you frequently notice swelling of your ankles, feet, hands, or face?

Yes No Do you have marked fatigue two to three hours after meals?

Yes No Do you eat snacks frequently between meals? List examples.

Yes No Do you have excessive chilling when a sudden change in temperature occurs?

Yes No Do you have frequent headaches or "Migraine?"

Yes No Do you experience belching, abdominal distention, indigestion, heartburn, bloating or cramps following meals? Circle which.

Yes No Have you noticed numbness of the face, arms, or legs at periodic intervals for no apparent cause?

Yes No Do you have drowsiness, headache or bloating following the ingestion of a cocktail, glass of beer or glass or wine? (Circle which)

Yes No Do you have alternating constipation and diarrhea?

Yes No Do you have dark circles, "bags" or swelling under your eyes?

Yes No Do you have fluctuating or blurring vision?

Yes No Do you have fluctuating ringing in the ears or dizziness?

Yes No Do you have bouts of nausea or vomiting after eating?

Yes No Do you dislike the taste of your tap water or do you feel that it causes symptoms?

Yes No Do you react to wood burning stoves, fireplaces, or kerosene space heaters?

Yes No Do you react when entering fabric shops, carpet stores, grocery stores, or department stores?

Yes No Do you react or dislike the odor of perfume, soap, detergents, colognes, or other solvents, such as fingernails polish remover, paint remover, model airplane glue, etc.?

Yes No Do you dislike or react to disinfectants, insecticides, sprays, ammonia, or moth balls?

Yes No Do you react or dislike the odor of Christmas trees or other indoor evergreen decorations, odor from sanding or woodworking, odor of a cedar closet, or pine-scented household deodorants, shampoos, or turpentine based paints?

Yes No Do you feel that you react to your working environment, either continuously or depending upon the area of the workplace that you are in?

Yes No Do you have hobbies that involve exposure to smells, odors, chemicals, paints, ceramics, or dusty, moldy, chemically contaminated areas?

Yes No Do you have a tendency to have unpleasant feelings or reactions to all medicines taken by mouth regardless of what condition they are given for?

Yes No Do you take large amounts of over-the-counter medications, such as vitamins, headache pills, sinus pills, etc.?

Yes No Do you react to other people's use of tobacco (cigarettes, pipes, cigars)?

Yes No Do you react to all types of fresh fruit and vegetables and improve if the substances are cooked or peeled?

Yes No Do you react to foods that are commercially prepared while not reacting to the same foods that are eaten fresh or prepared at home?

Yes No Do you have difficulty eating in restaurants, but are able to eat the same foods when prepared at home?

Yes No Do you feel that you perform or feel better in natural lighting compared to fluorescent lighting?

Yes No Do you react to newsprint or other printed material?

Yes No Have you taken tetracycline or other antibiotics for acne for one month or longer?

Yes No Have you at any time in your life taken other “Broad-spectrum” antibiotics for respiratory, urinary, or other infections for two months or longer, or in short courses four or more times in a one-year period?

Yes No Have you ever taken a broad-spectrum antibiotic (even a single course?

Yes No Have you at anytime in your life been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?

Yes No Have you been pregnant…..One time? Two or more times?

Yes No Have you taken birth control pills…For six months to two years? For more than two years?

Yes No Have you taken prednisone or other cortisone type drugs….for two weeks or less?
For more than two weeks?

Yes No Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke…
Mild symptoms? (5) Moderate to severe symptoms?

Yes No Are your symptoms worse on damp, muggy days or moldy places?

Yes No Have you had vaginitis, athlete's foot, ringworm, "jock itch," or other chronic or recurring fungal infections of the skin or nails? Mild to moderate? (10) Severe or persistent?)

Yes No Do you crave sugar?

Yes No Do you crave breads?

Yes No Do you crave alcoholic beverages?

Yes No Does tobacco smoke really bother you?

Yes No Do you have muscle pains and aches?

Yes No Do you have joint pains, swelling, stiffness or aches? Circle which

Yes No Do you have rheumatoid arthritis?

Yes No Do you have neck or shoulder muscle spasms?

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 often have "crying jags" for no apparent reason?

Yes No Are your depressions worse or more prevalent in the mornings when you wake up?

Yes No Are you following any particular nutritional program? Explain: ________________________

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Yes No Are you taking any vitamin or mineral supplements with your meals?

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