



Allergy Neutralization/Provocation New Patient Packet

*****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!

Avante Medical Center
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(907) 770-6700

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 of 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: _____

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