Ear, Nose & Throat Center of the Ozarks

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Patient Instruction/Consent Form for Allergy Skin Testing

Skin testing will be administered at this medical facility with a medical physician or 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, light headedness, faintness, nausea and vomiting, hives, generalized itching and anaphylactic shock (under extreme circumstances).
Please note that these reactions rarely occur but if you begin to experience symptoms, notify the clinician. Our staff is fully trained and emergency equipment is available.
A delayed reaction is unlikely but could occur. If you experience a reaction that is consistent with the above symptoms following allergy testing seek emergency care.

After the skin testing is complete the provider will review the results of the test and make a recommendation for further therapy. The follow-up with the healthcare provide may occur the same day as the test or at a later date.

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.

Patient: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____
*As a parent/legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.

Witness: _____ Date: _____

ALLERGY EVALUATION QUESTIONAIRE Date_____

Patient_____DOB_____Age_____

Please complete the following questions:

Have you ever had severe allergic reaction that required emergency care? YES / NO (if yes explain)

_____

_____

_____

_____

What are the problems that brought you here? And how long have they bothered you?

1._____

_____

2._____

_____

3._____

_____

4._____

_____

Have you ever been diagnosed with asthma? YES/NO

If you have asthma please check the following statements that describe your asthma

_____Asthma symptoms twice a week or more

_____Rescue bronchodilator (albuterol) use twice a week or more

_____Asthma symptoms that occur early in the morning or wake you up at night

_____Asthma symptoms that affect your ability to do exercise, work or school

_____PEF is less than 80% of highest recorded PEF

Would you describe your asthma as well-controlled? YES/NO

What other medical problems are you currently being treated for?

1._____

2._____

3._____

4._____

5._____

What medications are you currently taking? (Please list all in detail)

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

Please check the following statements that describe your symptoms (check all that apply)

_____Started in childhood
_____Started in adulthood
_____Are similar to other family members
_____Keep you from living a normal life
_____Are controlled by medication

Are you bothered by?

_____Grass
_____Tree Pollen
_____Ragweed
_____Wind
_____Dog
_____Cat
_____Horses
_____Perfumes
_____Pesticides
_____ Cows
_____ Barns
_____Weather Changes
_____Dusty places
_____Moldy places
_____Raking leaves
_____New buildings
_____Insect stings
_____smoke
_____medications
_____Other_____

History of past allergy treatment:

_____ I am currently on allergy treatment. What clinic? _____

_____ I have had allergy treatment in the past. What clinic? _____

How long ago? _____

_____ I have a history of allergies in my family. (explain)

_____

_____

Please list all known allergies:

_____

_____

_____

_____

Symptoms that you have currently or in the past: (circle all that apply)

- Nasal symptoms (runny nose or congestion)
- Ear symptoms (pressure, pain)
- Mouth and/or Throat (post nasal drainage, sore throat, hoarseness, difficulty swallowing)
- Eye symptoms (itchy, increased drainage)
- Headaches
- Breathing problems (shortness of breath, wheezing)
- Cough
    - At night
    - With exercise
- Stomach symptoms (acid reflux, nausea, diarrhea)
- Skin problems (urticaria, eczema)
- Sleep problems (snoring, difficulty falling asleep)

Where do your symptoms bother you the most?

_____Home

_____Work

_____School

Are you regularly exposed to pets or other animals? **YES / NO**

Do you have pets in your home?

What kind of animals? _____

Are you regularly exposed to smoke, perfumes, or other chemicals? **YES / N**

I.D.:_____ **SINO-NASAL OUTCOME TEST (SNOT-20)** DATE:_____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No problem	Very mild problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as bad as it can be	5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5	○
2. Sneezing	0	1	2	3	4	5	○
3. Runny nose	0	1	2	3	4	5	○
4. Cough	0	1	2	3	4	5	○
5. Post-nasal discharge	0	1	2	3	4	5	○
6. Thick nasal discharge	0	1	2	3	4	5	○
7. Ear fullness	0	1	2	3	4	5	○
8. Dizziness	0	1	2	3	4	5	○
9. Ear pain	0	1	2	3	4	5	○
10. Facial pain/pressure	0	1	2	3	4	5	○
11. Difficulty falling asleep	0	1	2	3	4	5	○
12. Wake up at night	0	1	2	3	4	5	○
13. Lack of a good night's sleep	0	1	2	3	4	5	○
14. Wake up tired	0	1	2	3	4	5	○
15. Fatigue	0	1	2	3	4	5	○
16. Reduced productivity	0	1	2	3	4	5	○
17. Reduced concentration	0	1	2	3	4	5	○
18. Frustrated/restless/irritable	0	1	2	3	4	5	○
19. Sad	0	1	2	3	4	5	○
20. Embarrassed	0	1	2	3	4	5	○

2. Please mark the most important items affecting your health (maximum of 5 items)_____ ↑

MEDICATION'S TO AVOID FOR 7 DAYS PRIOR TO ALLERGY TESTING:

1. Allegra (fexofenadine), Zyrtec (cetirizine), Claritin (loratadine).
2. Dymista (azelastine), Patanase (olopatadine)
3. Benadryl (diphenhydramine), Chlortab (chlorpheniramine)
4. OTC Sleep Aids (Tylenol PM, Ibuprofen PM, ZZZquil)
5. Hydroxyzine (Atarax, Vistaril)
6. Phenergan, meclizine, Dramamine
7. Combination cold and sinus medications that contain antihistamines

YOU CANNOT BE ALLERGY TESTED IF YOU ARE CURRENTLY TAKING:

BETA BLOCKERS: Metoprolol, propranolol, Zebeta, nadolol, acebutolol, atenolol, etc.

These are commonly prescribed for hypertension, heart conditions, glaucoma and headaches.

TRICYLIC ANTIDEPRESSANTS: Amitriptyline, Doxepin, nortriptyline, desimpramine, protryptyline, etc.

These are commonly prescribed for depression, obsessive compulsive disorder and bedwetting.