

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____

Date _____

Reviewed by _____

1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? Yes No
2. Have you ever been diagnosed with asthma or bronchitis? Yes No
3. Do you experience symptoms of allergies? Yes No

Allergy Questionnaire - Part 2

To be filled out with allergy counselor after initial screening

1. What symptoms are you experiencing? (From #1 on intake form) _____

2. How often do you experience these symptoms? _____
3. Do you have any of these symptoms?

<input type="checkbox"/> Cough	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Nasal Polyps	<input type="checkbox"/> Eczema
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Poor Sense of Smell	<input type="checkbox"/> Hives / Swelling
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Itchy Nose	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Headaches
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Itchy / Watery Eyes	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Snoring
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Postnasal Drip	<input type="checkbox"/> Blocked Ears	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Phlegm/sputum (Color _____)		<input type="checkbox"/> Other _____	
4. Which of the following seems to bother you or trigger/cause the above symptoms?

<input type="checkbox"/> Grass	<input type="checkbox"/> Cats	<input type="checkbox"/> Cosmetics	<input type="checkbox"/> Drafts
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Hay	<input type="checkbox"/> Dogs	<input type="checkbox"/> Aerosol sprays
<input type="checkbox"/> House Dust	<input type="checkbox"/> Cold Air	<input type="checkbox"/> Mold & Mildew	<input type="checkbox"/> Horses
<input type="checkbox"/> Perfumes	<input type="checkbox"/> Smoke	<input type="checkbox"/> Humidity	<input type="checkbox"/> Basements
<input type="checkbox"/> Other Animals	<input type="checkbox"/> Insecticides	<input type="checkbox"/> Pollution	<input type="checkbox"/> Weather changes
<input type="checkbox"/> Leaves	<input type="checkbox"/> Alcoholic beverages	<input type="checkbox"/> Odors	<input type="checkbox"/> Exercise
<input type="checkbox"/> Latex (rubber)	<input type="checkbox"/> Insect bites/stings. Describe reaction: _____		
<input type="checkbox"/> Foods. List foods and reactions: _____			
<input type="checkbox"/> Other. List sources and reaction: _____			
5. When are your symptoms worst? Year round

<input type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March	<input type="checkbox"/> April
<input type="checkbox"/> May	<input type="checkbox"/> June	<input type="checkbox"/> July	<input type="checkbox"/> August
<input type="checkbox"/> September	<input type="checkbox"/> October	<input type="checkbox"/> November	<input type="checkbox"/> December
6. Are symptoms better away from home? Yes No If yes, when? _____
7. Have you ever had an allergy skin test or blood test? Yes No If yes, results: _____
8. Have you ever had allergy injections? Yes No If yes, when? _____
9. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? Yes No
If yes, when? _____ How much? _____
10. Are you on allergy medications? Yes No What meds? _____
How much? _____ For how long? _____
11. What is your occupation? (current or former) _____

THIS SECTION FOR PROVIDER AND OFFICE USE ONLY

Is patient...

On beta blocker? Pregnant? Heavily tattooed?

Significantly immunocompromised or have malignancy or severe chronic illness?

If yes to above, select blood test

Wheezing or having difficulty breathing?

Experiencing active hives or extensive dermatitis?

If yes to above, treat symptoms and schedule for another day

Having symptoms consistent with food allergies?

If yes to above, consider skin panel and food panel

Indications

Inhalant Panels: Skin Test Blood Test

Food Panels: Skin Test Blood Test

Schedule skin test for (Date) _____

Patient Name

Date

Reviewed by

Allergy Questionnaire - Part 3

To be filled out by patient during test development

ENVIRONMENTAL SURVEY

- How long have you lived in your house/apartment? _____
- Do you live in a House Apartment/duplex Condominium/townhouse
- Approximately how old is your home? _____
- Do you live in City Suburbs Rural area
- Do you have a basement? Yes No
- Type of heating: hot air steam (radiator) electric hot water (baseboard)
- Do you have: Wood /coal stove or fireplace Humidifier Dehumidifier Air cleaner
- Number of pets (indoor or outdoor) ___Cats ___Dogs ___Birds ___Other
- Are there any tobacco smokers in your home? Yes No
- Is your bedroom in the basement? Yes No
- Do you have allergy-proof encasing for pillow or mattress? Yes No
- What type of pillows do you have? _____
- What type of comforter do you have? _____
- What type of floor covering do you have in your bedroom? Wall to wall Area rug Animal skin Bare floor
- How old is your mattress? _____ What's inside your mattress? (i.e. cotton/horse hair) _____
- Do you have air conditioning? Yes No If yes, is it: Window unit Central
- Do you have problems with roaches or mice? Yes No
- Do you have water leaks, mold contamination? Yes No
- Is your home/apartment excessively humid? Yes No
- Do you experience runny nose or sneezing in response to eating? Yes No
- Do you experience runny nose or sneezing in response to strong odors? Yes No
- Do you experience runny nose or sneezing in response to exercise? Yes No
- Do you experience runny nose in response to emotional upset? Yes No

MEDICAL HISTORY

- Check all that apply:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease/hepatitis	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Heartburn/reflux
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems/murmur	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Anemia/blood disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Depression
<input type="checkbox"/> Kidney/bladder disease	<input type="checkbox"/> Gynecological problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Back problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Emphysema			
- If yes to any of above, please explain: _____
- Have you had your tonsils or adenoids removed? Yes No
- Have you had ear, nose or sinus surgery? Yes No
- If yes, please explain: _____
- Who in your family has had: (NOT including yourself)

<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Eczema _____
<input type="checkbox"/> Seasonal /year round allergies _____	<input type="checkbox"/> Sinus problems _____
<input type="checkbox"/> Other allergies (drugs/bee sting/food etc) _____	
- Do you smoke? Yes No If yes, how much? _____
- Have you smoked in the past? Yes No How long ago did you stop? _____
- How many years did you smoke? _____

Patient Name _____

Date _____

Reviewed by _____

What should I do, or not do, before my allergy test?

- Do not take antihistamines for three days before testing. If this is not possible, contact your provider to discuss options so you can undergo the allergy test as scheduled!
- Notify your provider before the test if you take beta blockers (blood pressure medication). If you are using beta blockers at the time of testing, your provider will perform a blood test instead of a skin test.
- Alert your provider if there's any chance you're pregnant. He or she can test for pregnancy before the skin test. If you *are* pregnant, you will receive a blood test instead of a skin test.
- Tell your provider if you are experiencing any signs of a severe allergic reaction on the day of testing (e.g. hives or difficulty breathing).
- Inform your provider if you have been diagnosed with cancer or an immune disorder.

What should I expect during testing?

Your provider will clean your skin on your back with an alcohol swab. That will feel cool and slightly wet. He or she will warn you before the testing begins. As the first set of antigens is applied to your skin, you'll feel minor pressure from the tines of the testing device. This will last for just a few seconds and then be repeated in five areas. You can expect slight discomfort, as well as some itchiness from positive results. Try to avoid scratching while the test develops. Notify your provider if you feel symptoms other than itchiness.

Will the tines penetrate my skin?

No, the testing unit (MAST device) is pressed onto your skin; no blood is drawn. If a spot of blood does appear, the provider simply blots the area and continues the procedure.

How long will it take for results to develop?

Results will be available in just 15 minutes. An allergy technician will check on you every five minutes or so during that time to make sure you are okay. After 15 minutes, he or she will read the results and remove the antigens with an alcohol swab.

What if I am extremely uncomfortable with reactions before 15 minutes are up?

If you have clearly positive reactions and are very uncomfortable, the technician will wipe the antigen off and read the results early.

How does my provider measure the reaction?

Reactions are evaluated by measuring raised areas of skin with a millimeter ruler. Allergic severity is graded as follows: 2-4mm=low; 5-7=moderate; 8-10=high; 11-13=very high.

What happens after the test?

The provider wipes the antigens off the skin with alcohol wipes. You may then receive hydrocortisone cream and/or oral Claritin if necessary to ease any lingering discomfort or itchiness. Then your provider will explain the results and discuss your options for treatment, if applicable.

How long will the reaction last after testing?

Itching begins to resolve as soon as the antigen is wiped away. Bumps usually last about an hour. In rare cases, the reaction may last longer but it is generally not uncomfortable. For the very rare cases of lasting reaction, Claritin and hydrocortisone cream help minimize discomfort.

How much does testing cost?

It is covered by most insurance plans. You will only be responsible for your regular co-pay and deductible.

Is there an age limit for testing and treatment?

No. Small children will be tested for fewer antigens than older children and adults, but the test is safe for children of any age.

Can I be tested if I have a skin condition or moles?

Yes. If possible, your provider will place the test on areas that are not acutely affected. If there are no unaffected areas, you will receive a blood test instead of a skin test.

Can I be tested if I have a tattoo?

Yes. The technician will place the test on areas that are not inked. He or she may use ink-free areas on your back, arms, or legs. If you are inked in all areas, you will receive a blood test instead of a skin test.



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West Atlanta Pediatrics has made every effort to obtain accurate benefit information for allergy skin testing.

In the event that my insurance does not cover my child's allergy skin testing, I understand that I will be responsible for any balance owed. I also understand that I have a responsibility to verify and understand my insurance coverage for these services.

Child's Name: _____ Child's Date of Birth: _____

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

Allergy Skin Test Consent

Allergy skin testing is an important diagnostic tool used by medical providers to accurately diagnose the source of allergic reaction. Correct diagnosis through testing that identifies the specific antigens causing your symptoms is an important first step to providing you with the best and most complete range of treatment options.

By managing allergic conditions, you may reduce the number of days you miss work or school, and you may eliminate (or lessen the severity of) symptoms such as attention deficit and impaired ability to concentrate.

The skin test is performed by the same process used in an allergist's office: placement of multiple antigens on the back or other body part, to be determined by your provider, with a plastic skin test applicator. This test is extremely accurate and results are read in 15 minutes.

There is a low risk of persistent itching or discomfort, and an extremely low risk of anaphylaxis associated with skin testing.

The cost of test varies by health plan, but most health plans cover the test in-network. Please note that insurance deductibles, co-insurance and co-payments may apply. If the test is not covered by your insurance plan, you will be responsible for the cost of the test.

Please confirm that you understand the reasons for the test as well as the potential benefits and risk involved:

Date _____ Time _____

Patient Name _____

Signature of Patient or Parent/Guardian _____

Name of Parent/Guardian _____

ALLERVISION | *Beta Blockers*

Review patients' medical history for beta blockers. **Do not skin test if patient is on a beta blocker** — postpone skin test until 72 hours after last dose of beta blocker or perform a blood test.

Patients taking a beta blocker cannot receive allergy injection treatment.

This list may not include all beta blockers currently on the market. If you are unsure of the class of a patient's medication or require a comprehensive list, consult the PDR.

GENERIC Name	BRAND Name
• Acebutolol	• Betagan [®]
• Atenolol	• Betapace [®]
• Betaxolol	• Betimol [®]
• Bisoprolol	• Betoptic [®]
• Carvedilol	• Blocadren [®]
• Carteolol	• Brevibloc [®]
• Esmolol	• Bystolic [®]
• Labetalol	• Coreg [®]
• Levobunolol	• Coreg CR [®]
• Metipranolol	• Corgard [®]
• Metoprolol	• Inderal [®]
• Nadolol	• Inderal LA [®]
• Nebivolol	• InnoPran XL [®]
• Penbutolol	• Istalol [®]
• Pindolol	• Kerlone [®]
• Propranolol	• Levatol [®]
• Sotalol	• Lopressor [®]
• Timolol	• OptiPranolol [®]
	• Ocupress [®]
	• Sectral [®]
	• Sorine [®]
	• Tenormin [®]
	• Timoptic [®]
	• Toprol-XL [®]
	• Trandate [®]
	• TSectral [®]
	• Visken [®]
	• Zebeta [®]