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Allergy and Immunology Department

Welcome to the South Bend Clinic Allergy, Asthma and Immunology Department.

We look forward to working with you to develop a treatment plan and/or regimens to assist you in managing your seasonal/chronic allergy symptoms, asthma or respiratory immune disorders.

As your first appointment is approaching, we want to provide you with some information to help you prepare.

What is involved with a "New Patient Evaluation?"

Many new patients come to the allergist due to ongoing problems with asthma management, chronic/seasonal allergy symptoms or even hives. You will need to provide a complete medical history, including treatments already tried and their effects. You may require allergy testing (also called skin or prick testing) a spirometry or pulmonary function test, lab work, an X-ray (or other radiology tests) and/or patch testing; all of which will help the physician in the management of your particular problem.

You should plan on your initial visit taking 3-4 hours, though it may take less. We are not able to predict which test or tests you will need ahead of time.

What is allergy testing?

Allergy testing involves monitoring your response or reaction to specific allergens or triggers in a controlled setting. Through allergy testing, the physician can determine which specific allergens are causing your symptoms.

Allergy testing usually involves a very small amount of liquid (allergen) material being placed on your skin via a "prick" test. The "prick" site is evaluated approximately 15 minutes after application of allergen. Sometimes the physician may also use the liquid material for intradermal skin testing. This is similar to a TB test.

My physician ordered a "PFT." What is a PFT (pulmonary function test)

A PFT or spirometry, provides the physician with information about how well your lungs are functioning under normal circumstances and when you push then to capacity.

Medications to Stop 5 Days Prior to Allergy Testing

Advil PM	Ahist	Alka-Seltzer Plus	Allegra; Allegra-D
Allerest PE	Atarax	Cetirizine; Cetirizine-D	Chlorpheniramine
Chlor-Trimeton	Cimetidine	Comtrex	Coricdin HBP
Cyproheptadine	Dimenhydrinate	Dimetapp	Dramamine
Dristan Cold	Famotidine	Fexofenadine; Fexofenadine-D	Hydroxyzine
Levocetirizine	Loratidine; Loratidine-D	Meclizine	Periactin
Pepcid; Pepcid AC	Phenergan	Ranitidine	Semprex-D
Stahist-AD	Sudafed	Sudogest; Sudogest PE	Tagamet
Tussionex	Tyelonl PM	Vistaril	Walatin
Wal-phed;Walphed PE	Xyzal	Zantac	Zyrtec-Zyrtec-D

If you need a "rescue" antihistamine, you may use a Benadryl (diphenhydramine) up to 3 days prior to your appointment.

ANTIDEPRESSANTS WITH PROPERTIES LIKE ANTIHISTAMINES: **Ask the prescribing doctor before stopping the medication. Those medications are:**

Amitriptyline(Elavil, Endep, Etrafon, Limbitrol)	**Imipramine (tofranil)**	**Amoxapine(Asendin)**
Nortriptyline(Pamelor)	**Clomipramine(Anadranil)**	**Protriptyline (Vivactil)**
Desipramine(Norpramin)	**Quetipine(Seroquel)**	**Doxepin(Sinuquan, Adapin)**
Trimipramine (Surmontil)		

NASAL SPRAYS- hold for 2 days prior to testing. May continue other nasal sprays such as Flonase.

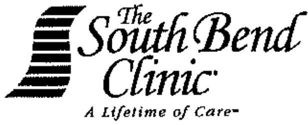
Astelin(Azelastine) **Patanase** **Dymista**

STEROIDS

Prednisone at 20 mg per day and methylprednisone(Medrol) at 16mg per day can interfere with skin testing. Injected steroids and topical steroids applied to skin may also interfere.

*****ASTHMA INHALERS, INCLUDING INHALED STEROIDS DO NOT INTERFERE WITH SKIN TESTING AND SHOULD NOT BE STOPPED.**

****Singulair(Montelukast) and Accolate(zafirlukast) and Zyflo should not be stopped.**



New Patient History Form
South Bend Clinic Allergy Department
Patients 5 years and older

Patient Name: ____________________ **Date of Birth:** ______________ **Today's Date:** _____________
Name of person completing form: ____
Relationship to patient, if not "self": ____

Physician you are seeing today: ____
Chief Complaint / Purpose of visit today: ____
Please list the concerns you would like to discuss with the physician:
____
____
____

Past medical / Past surgical history:
Please list all **MEDICAL PROBLEMS, HOSPITAL STAYS,** or **SURGERIES** that you have had (including dates)
____
____
____
____

Please List all MEDICATIONS or DRUGS you are currently taking, including over-the-counter medications. (Include dosages and frequency, if known)
____
____
____
____
____
____
____

Please list any known MEDICATION ALLERGIES ☐ **Check here if no drug allergies**

Name of medication	Reaction (+ date)	Name of medication	Reaction (+ date)

Social / Environment:
If patient is a child (< 18 years old), with whom does the patient live? ______________________________
Are the parents: married / divorced / separated / other: ______________________________
Please list other people involved in care of child ______________________________
Current grade in school: ____________
If patient is an adult
Marital status: Single / Married / Separated / Divorced / Widowed
Children? Yes / No If yes, please list ages and names of children: ______________________________
What is the last grade or level of education you have completed? ______________________________
Are you currently employed? Yes / No If yes, what is your current job description? ____________________
____
Place of residence: House / Apartment / Townhouse / Mobile home / Dormitory
Heat source: Gas / Oil / Wood
Humidifier? Yes / No If yes, are they: Console furnace / Vaporizer Functional: Yes / No
Do you have allergy filters in your home? Yes / No
If yes, are they: free standing / on the furnace / both
Is there a basement? Yes / No
Is there carpeting? Yes / No
Do you have any allergy covers on your mattress and pillow? Yes / No
Do you have any pets? Yes / No If yes, please list: ______________________________
Are there any smokers in the family? Yes / No If yes, who? ______________________________

Review of Systems: Please circle all that apply

Constitutional:	Fever Weight loss Weight gain Fatigue	None of these
Special senses:	Glaucoma Itching in ears Loss of smell/taste Dry, itchy, watery eyes Nasal Congestion	None of these
Lymph glands:	Glandular swelling Glandular tenderness	None of these
Heart:	Chest pain Palpitations Swelling Inability to lie flat in bed	None of these
Intestinal tract:	Nausea Vomiting Indigestion/heartburn Constipation Diarrhea Excessive gas Trouble swallowing liquids or foods Cramping Bloating	None of these
Reproductive:	Irregular periods Menopause	None of these
Urinary:	Kidney stones Inability to urinate Prostate problems Kidney infections	None of these
Rheumatologic & Orthopedic:	Joint swelling Joint pain Osteoporosis / Osteopenia	None of these
Skin:	Rash Hives Itching Eczema	None of these
Neurological:	Headaches Epilepsy (seizures)	None of these
Respiratory:	Wheezing Shortness of breath Pneumonia	None of these

List any **MEDICAL PROBLEMS** in your family, especially allergies, asthma, sinus problems, cystic fibrosis, or immune problems

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____

____

Do you use any **ALCOHOL**? YES / NO If yes, how much, how often: ______________________

Do you now, or have you in the past, **SMOKED** or **USED TOBACCO?**

Never / Now / Past / Quit when? ______________

If yes: How many packs per day? ______________

For how many years? ______________

VACCINE history:

Are your childhood immunizations up-to-date? ______________

When was your last TETANUS shot? ______________

When was your last PNEUMONIA shot? ______________

Do you receive an annual flu vaccine? ______________

Please list names of other physicians you are currently seeing

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____

Attending Physician Signature: ______________________ **Date:** ____________

Form Reviewed: Dates:	**Signature:**
____________	____________________
____________	____________________
____________	____________________
____________	____________________
____________	____________________

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