The South Bend Clinic
A Lifetime of Care

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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.

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## 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.**

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**New Pediatric Patient History Form**
South Bend Clinic Allergy Department
(For use with patients < 5 years old)

**Patient Name:** _____ **Date of Birth:** _____ **Today's Date:** _____
**Name of person completing form:** _____
**Relationship to patient:** _____

**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:**
Are the parents: married / divorced / separated / other: _____
With whom does the patient live? _____
Please list other people involved in care of child or other households the patient is in on a regular basis, such as blended family situations, grandparents, etc.: _____
Is the child in a daycare / pre school? Yes / No If yes, how often? _____
Full term / Premature as an infant? (circle) Birth Weight _____
Feeding: Breast, Formula, Both (circle) If currently taking formula, what type? _____
Is the child on any special dietary restrictions? _____
Known or suspected food allergies: _____
**Place of residence:** House / Apartment / Townhouse / Mobile home / Dormitory
Heat source: Gas / Oil / Wood
Humidifier? Yes / No (console furnace / Vaporizer) Functional: No / Yes
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 Night sweats Fatigue | None of these |
| **Special senses:** | Glaucoma Itching in ears Loss of smell/taste<br>Dry, itchy, watery eyes Nasal congestion | None of these |
| **Lymph glands:** | Glandular swelling Glandular tenderness | None of these |
| **Heart:** | Chest pain Palpitations Swelling of ankles Inability to lie flat in bed | None of these |
| **Intestinal tract:** | Nausea Vomiting Indigestion/heartburn Constipation Diarrhea<br>Excessive gas Trouble swallowing liquids or foods Cramping Bloating | None of These |
| **Urinary:** | Kidney stones Inability to urinate Kidney Infections | None of These |
| **Rheumatologic & Orthopedic:** | Joint swelling Joint pain | 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

_____

_____

_____

_____

**VACCINE** history:

Are the patient's childhood immunizations up-to-date? _____
When was the patient's last TETANUS shot? _____
When was the patient's last PNEUMONIA shot? _____
Does the patient receive an annual flu vaccine? _____

Please list names of other physicians you are currently seeing

_____

_____

_____

_____

**Attending Physician Signature:** _____ **Date:** _____

| **Form Reviewed: Dates:** | **Signature:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |