AllergywoRx Patient Symptom Survey

Last Name: _____ First Name: _____ Date of Birth: _____

Home Address: _____ ( ) Female ( ) Male

Home Phone: _____ Mobile Phone: _____ Email: _____

COMMON SYMPTOMS: Circle the number according to severity: 0 = NONE, 2 = MILD, 4 = SEVERE

Nasal Congestion	0	1	2	3	4	Fatigue	0	1	2	3	4
Watery, red, itchy eyes	0	1	2	3	4	Frequent sinus or ear infection	0	1	2	3	4
Sneezing	0	1	2	3	4	Frequent colds or sore throat	0	1	2	3	4
Wheezing	0	1	2	3	4	Trouble breathing while sleeping	0	1	2	3	4
Cough	0	1	2	3	4	Poor memory or concentration	0	1	2	3	4
Itching	0	1	2	3	4	Hyperactivity	0	1	2	3	4
Eczema	0	1	2	3	4	Abdominal gas or cramping	0	1	2	3	4
Hives	0	1	2	3	4	Arthritis or muscle aching	0	1	2	3	4
Headache	0	1	2	3	4	Asthma	0	1	2	3	4

SYMPTOM SCORE: _____ List any other symptoms: _____

1. Do you experience sensitivity to any particular foods ? ( ) Yes ( ) No

   If yes, what are your symptoms? _____
2. Do you have a history of allergies? ( ) Yes ( ) No

   If yes, please answer the following:

   How long have you experienced symptoms: _____

   What season(s) do your allergies flair up? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) All Year

   How would you describe the frequency of your symptoms? ( ) Constant ( ) Intermittent
3. Have you been tested for allergies? ( ) Yes ( ) No

   If yes, have you ever received allergy shots as a form therapy? ( ) Yes ( ) No

   Have you ever taken prescription medications to treat allergies symptoms? ( ) Yes ( ) No

   If yes, which medications and for how long did you take medications? _____

   _____

   Does any medication relieve you of allergy symptoms? ( ) Yes ( ) No Comments: _____
4. Do you have pets at home? ( ) Yes ( ) No Do they cause symptoms? _____
5. Are you exposed to fumes or dust at work? ( ) Yes ( ) No
6. Do you smoke? ( ) Yes ( ) No How often? _____ Do you work in a smoky environment? ( ) Yes ( ) No
7. Does anyone in your family have allergies or asthma? ( ) Yes ( ) No
8. Have you ever been diagnosed with asthma? ( ) Yes ( ) No Age diagnosed_____ Severity: ( ) Mild ( ) Moderate ( ) High

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Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No

Have you ever had a severe allergic reaction? ( ) Yes ( ) No

Have you been hospitalized due to allergies or asthma? ( ) Yes ( ) No

Taking Beta Blockers to treat heart disease? ( ) Yes ( ) No Name of Medication: _____

If you answered YES to any of the questions in bold, you will be asked to see the clinician as allergy testing may be contraindicated.)

Reviewed By: _____

Provider: _____ Date: _____

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INSTRUCTIONS FOR SCHEDULED AllergywoRx TEST

You have been scheduled for allergy testing on _____ at _____.

If you have any questions, concerns or need to reschedule your appointment, please contact

_____ at _____.

1. Allow one hour for allergy testing. If you are running late, please contact our office immediately. We can usually complete your testing in one appointment. In some cases, however, you may need to return to complete the testing process.

2. We will contact your insurance company for benefit and eligibility information. We cannot guarantee benefits quoted by your insurance company, but will try our best to get the information prior to the AllergywoRx SkinTest.

3. *If you have asthma, you MUST bring all prescribed medications, inhalers and nebulizers to your allergy testing.* If you do not bring your medications to your testing appointment, you will need to be rescheduled for another day. If you feel ill or have tightness in your chest the day of testing, please contact our office before coming to your appointment.

4. Do not wear perfume or cologne to your testing. If worn, allergy testing will not be performed. This includes patient and/or family member. You may wear deodorant and mild lotions.

5. Do not skip any meals before testing. Make sure to eat breakfast before coming for a morning appointment and lunch before an afternoon appointment.

6. Allergy testing requires that your physician have access to your upper arms and back for the test. Please plan accordingly.

7. Please review the list of below and address any questions/concerns with your nurse or provider. The following medications can interfere with your test and may suppress any potential reactions.

PLEASE AVOID ANTIHISTAMINES AND COUGH, COLD OR DECONGESTANT MEDICATIONS, SUCH AS THE FOLLOWING, FOR 5 TO 7 DAYS PRIOR TO TEST.

Actifed	Chlorphenerimine	Nolamine	Sinulin	* **NASAL SPRAYS:**
Alavert (loratadine)	Clarinex (desloratadine)	Opcon-A (eye drops)	Taoist	Astelin
Allegra (fexofenadine)	Claritin (loratadine)	Patanol (eye drops)	Tussinex	Aster
Astelin	Codimal DH Syrup	Periactin	Trinalin	Patanase
Atarax	Dimetane Cough Syrup	Phenegran	Tylenol Allergy	
Athrohist	Dura-Vent	Rondec	Tylenol Cold	
Benadryl (diphenhydramine)	Extendryl	Rynatan	Tylenol Flu	
Bromfed	Hycomine Compound	Rynatuss	Visatril	
Bromphenerimine	Kronofed	Semprex	Xyzal	
Chlor-triton	Nolahist	Singulair	Zyrtec (cetirizine)	

Patient may take aspirin, Motrin or Tylenol, but DO NOT STOP TAKING BETA BLOCKERS!

CONSENT FORM FOR PERCUTANEOUS TESTING

Percutaneous allergy skin testing is a clinical procedure that is used to evaluate an immunologic response to allergenic material. The need for testing and interpretation of test findings must be correlated with signs and symptoms of possible allergies as determined by a complete history and physical examination of the patient. The number and type of antigens used for testing must be chosen judiciously given the patient's presentation and the tester's clinical judgement. The AllergywoRx test consists of the top 72 environmental allergens across all regions of North America.

Percutaneous testing is the preferred method for allergy testing. Medicare covers percutaneous (scratch, prick or puncture) testing when IgE-medicated reactions occur to any of environmental (inhalant) allergens such as pollen (trees, weeds and grasses), molds, fungi, animals (dogs, cat, cattle, horse, mice dander) or insects (cockroach or dust mites).

By signing below, I give my consent for _____ (patient) to have percutaneous testing administered, which has been prescribed by my physician. I acknowledge that an adverse reaction can occur because the test will administer material to which I may be allergic. Although any reaction is generally rare, the most common reaction could be an area of local swelling and redness at the site of the skin test indicating a positive result. Rarely more severe reactions occur. Rare but severe reactions can include hives, wheezing, sneezing, itching in the palms of the hands, nose, roof of mouth or throat, urticarial and even low blood pressure (with death being reported in extremely rare circumstances).

Please note that it is extremely important that you wait 20 to 30 minutes after the administration for observation so please plan accordingly. If you suspect a reaction after test administration, immediately call 9-1-1.

By signing below I give my consent and acknowledge that i have read the above information provided to me and that I fully understand the possibility an adverse reaction can occur.

Patient Name: _____ **Date:** _____

Patient or Responsible Party Signature: _____

Allergy Tech Name: _____ **Date:** _____

Allergy Tech Signature: _____