ALLERGY NEW PATIENT - MEDICATIONS TO STOP TAKING 5 DAYS BEFORE ALLERGY TESTING

To do allergy testing, specific medications termed antihistamines need to be discontinued 5 days prior to testing. You DO NOT need to stop decongestants, but please note that many brands available over the counter combine decongestants with antihistamines. If you are not sure, please call our office to clarify (330) 543-0140.

***DO NOT STOP ANY MEDICATIONS FOR ASTHMA. INHALERS AND MONTELUKAST MAY BE CONTINUED.**
***DO NOT STOP ANY MEDICATIONS FOR HIVES.**
***DO NOT STOP ANY HEART, DIABETES, HIGH BLOOD PRESSURE, ANTIBIOTICS OR PSYCHIATRIC MEDICATIONS: DEPRESSION and ANXIETY**

STOP ALL ANTIHISTAMINE MEDICATIONS 5 DAYS BEFORE YOUR VISIT

MOST COMMON

Loratadine (Alavert/Claritin)

Desloratadine (Clarinex)

Fexofenadine (Allegra)

Levocetirizine (Xyzal)

Cetirizine (Zyrtec)

Diphenhydramine (Unisom, Diphedryl, Benadryl)

Chlorpheniramine (Aller-Chlor, C.P.M., Chlo-Amine, Chlor-Allergy, Chlor-Mal, Chlor-Trimeton, Chlorphen and other Triaminic products)

Clemastine (Allerhist-1, Contac 12 hr Allergy)

Brompheniramine (Dimetapp and Dimetapp products)

Hydroxyzine (Atarax, Rezine)

Pyrlamine (Tussi products)

Cyproheptadine (Periactin)

Promethazine (Phenergan)

Tylenol PM (All)

NASAL SPRAYS

Azelastine (Astepro, Astelin)

Olopatadine (Patanase)

Corticosteroid nose sprays DO NOT need to be stopped:
Flonase, Nasonex, Nasacort, Rhinocort, Veramyst, Nasarel, QNasl, Zetonna and Omnaris
Generic names include:
Budesonide, Fluticasone, triamcinolone mometasone, Ciclesonide, beclomethasone

EYE DROPS

Visine-A

Azelastine (Optivar)

Ketotifen (Zaditor, Alaway)

Epinastine (Elestat)

Olopatadine (Patanol, Pataday and Pazeo)

Opticon/Opcon-A

Levocabastine (Livostin)

Alcaftadine (Lastacaft)

DO NOT STOP ANY EYE DROP FOR OTHER EYE CONDITIONS SUCH AS GLAUCOMA OR INFECTIONS

LEAST COMMON

Comtrex Calm-Aid

Tanafed Scot-Tussin Allergy

Polaramine Sominex

Semprex Hydramine

Any product with:

Carboximine, Triprolidine HCL, Dosylamine succinate

Dexbrompheniramine (Drixoral)

Tripelennamine (PBZ & PBZ-SR)

Meclizine (Bonine Triaminic)

Pediacare Products

Carbinoxamine (Duradryl/Rondec Genahist)

ANTI ACID MEDICATIONS

Ranitidine (Zantac)

Famotidine (Pepcid)

Cimetidine (Tagamet)

Nizatidine (Axid)

Akron Children's

ALLERGY, ASTHMA & IMMUNOLOGY NEW PATIENT

Name:_____
Birth Date:_____
Age:_____
Sex:_____

PRIMARY REASON FOR TODAY'S VISIT?
List your 3 primary allergy concerns in order of importance.
Additional concerns may require a return visit:

1. _____
2. _____
3. _____

Primary Care Physician:_____
Other Medical Specialist Physician(s): _____

CURRENT MEDICATIONS:
Include over the counter, supplements and dosage:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Are vaccinations up to date? YES ☐ NO ☐
Did you receive the flu vaccine? YES ☐ NO ☐

MEDICAL HISTORY:

1. Have you had any hospitalizations, emergency room visits or urgent care visits in the past year? NO ☐
   *EXPLAIN:*_____
2. Have you had any allergic reactions requiring use of Epinephrine? NO ☐
   *EXPLAIN:*_____
3. Have you used any antihistamine medications within the last 5 days? NO ☐
   Zyrtec (Cetirizine) ☐ Benadryl ☐ Allegra ☐ Claritin ☐ Other: (refer to medication list attached) ☐
4. Are you treated for any medical conditions? NO ☐
   LIST: 1. _____ 2. _____ 3. _____ 4. _____
5. Have you had surgery: Sinus ☐ Tonsil Removal ☐ Adenoid Removal ☐ Ear Tubes ☐
6. Do you have any drug or medication allergies? NO ☐
   LIST: 1. _____ 2. _____ 3. _____ 4. _____
7. Does anyone in your family have:

Asthma ☐ Mother ☐ Father ☐
Eczema ☐ Mother ☐ Father ☐
Food Allergies ☐ Mother ☐ Father ☐
Immunodeficiency ☐ Mother ☐ Father ☐
Autoimmune Disease ☐ Mother ☐ Father ☐

SOCIAL HISTORY:

1. How long have you lived in your current home? _____ Have you recently moved? YES ☐ NO ☐
2. Do you smoke or are you exposed to smoke in the home? NO ☐ Years of use or exposure:_____
3. Are there any pets in the home or animal exposure? NO ☐ LIST:_____

ASTHMA:

1. Do you have any asthma symptoms: cough, wheeze or shortness of breath? YES-EXPLAIN BELOW ☐ NO ☐
   *EXPLAIN:*_____
2. Date of last oral steroid use (prednisone, prednisolone, dexamethasone, etc): DATE:_____ NONE: ☐

DAYTIME asthma symptoms:
[ ] 0-2 days per week
[ ] 3-6 days per week
[ ] Once per day
[ ] More than once per day

NIGHTIME asthma symptoms:
[ ] 0-2 nights per week
[ ] 3-6 nights per week
[ ] Once per night
[ ] More than once per night

Albuterol use:
[ ] 0-2 times a week
[ ] 3-6 times a week
[ ] Once per day
[ ] More than once per day
[ ] With exercise only

HAVE YOU BEEN TREATED FOR ANY INFECTIONS:

[ ] Pneumonia
[ ] Sinus
[ ] Ear
[ ] Other_____
Have you been hospitalized for any infections?
DATE:_____
EXPLAIN:_____

ADDITIONAL COMMENTS:

_____
_____
_____
_____
_____
_____