Allergy & Immunology Department
130 W. Exchange St., Akron OH 44302
(330) 543-0140

WELCOME TO OUR OFFICE,

Please complete the following information and bring it with you the day of the appointment. If you would like, you may mail it to: ***Allergy & Immunology Department, One Perkins Square, Akron OH 44308*** or you can fax your information to (330) 543-5207. Please make sure to place the date of the appointment on the paperwork.

The date and time of your appointment is:_____

with

Rajeev Kishore, MD Ravi Karnani, MD Erik White, MD Jinzhu Li, BM, Ph.D. Mary George, NP

Please make sure you arrive fifteen minutes before your scheduled appointment time for registration at the front desk. If you are more than fifteen minutes late, we may have to reschedule your appointment.

****Please call 330-543-4300 to Preregister before your appointment with your insurance information.***

- Make sure you bring your insurance card and photo identification to **every** appointment.
- Please complete the enclosed patient history forms as best applies to the patient.
- Please check the attached information sheet regarding medications that need to be held for one week prior to testing. Please do ***not*** hold medications that are used for any medical condition other than allergies. If you are having an increase of symptoms (***this includes HIVES and Asthma Flares)*** or are acutely ill at the time of your appointment, we do **NOT** want you to hold any of your medications.
- Please check with your insurance company to make sure we are contracted with them if you are unsure.
- Co-pays are due *at* the time of service. We accept MasterCard, Visa, Discover, Cash or Check. If we are not contracted with your insurance company there are financial services available through Akron Children's Hospital.
- *Cancellations:* If you are not able to keep your scheduled appointment, please call us as soon as possible to cancel or reschedule. For your convenience you can leave a message on our cancellation line, which is: 330-543-0140, option 9.
- **Important:** Please do not wear perfumes, hair sprays, body lotions, colognes or other types of scented items to our office. Many of our patients are very sensitive to those items and exposure to these may cause our patients to become ill. We also do not allow food or beverages in our office because of patients with food allergies.

Please call us if you have any questions regarding the above information.

Thank You,

Allergy & Immunology Department

ALLERGY TESTING

In order to do allergy testing, antihistamines need to be stopped prior to the 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, do not take the medicine.

DO NOT STOP ANY MEDICATIONS FOR ASTHMA OR HIVES

DO NOT STOP ANY HEART, DIABETES, HIGH BLOOD PRESSURE, ANTIBIOTICS OR OTHER MEDICATIONS FOR CHRONIC CONDITIONS

STOP 5-7 DAYS PRIOR TO TESTING	**STOP 3-5 DAYS PRIOR TO TESTING**	**STOP 48-72 HOURS PRIOR TO TESTING**
Alavert/ Claritin (Loratadine) Clarinex Allegra (Fexofenadine) Xyzal Zyrtec Aller-Chlor, C.P.M., Chlo-Amine, Chlor-Allergy, Chlor-Mal, Chlor-Trimeton, Chlorphen (Chlorpheniramine) Allerhist-1, Contac 12 hr Allergy, Tavist -1(Clemastine) Periactin Atarax. Rezine (Hydroxyzine) PBZ & PBZ-SR (Tripelennamine) Phenergan Promethazine Prorex Zantac (Ranitidine)	Extendryl Actifed Sinus Day AllerX Aler-Dryl Tussi products (pyrlamine) Benadryl Comtrex Calm-Aid Rynatan Compoz Nighttime Unisom Diphedryl Benadryl (Diphenhydramine) Diphen-Allergy Duradryl/Rondec Genahist Semprex Hydramine Tylenol PM Nytol Tanafed Scot-Tussin Allergy Polaramine Sominex Tylenol PM Twilite Unisom Sleepgels	Dimetapp (Brompheniramine) Bonine (Meclizine) Triaminic Dimetapp Products Pediacare Products Any product with: Carboximine Triprolidine HCL Dosylamine succinate Drixoral (Dexbrompheniramine)

STOP 24 HOURS PRIOR TO TESTING (Eye Drops)	**STOP 24 HOURS PRIOR TO TESTING (Nasal Sprays)**	**DECONGESTANTS OKAY TO TAKE**
Visine-A Optivar Zaditor Elestat Alaway Vascaon Patanol Opticon Pataday Livostin **DO NOT STOP ANY EYE DROP FOR OTHER EYE CONDITIONS SUCH AS GLAUCOMA OR INFECTIONS**	Astepro Astelin Patanase **Corticosteroid nose sprays do not need to be stopped (Flonase, Nasonex, Nasacort, Rhinocort, Veramyst, Nasarel)**	Sudafed – Pseudoephedrine Afrin Nasal products Neosynephrine nasal products Phenylephrin

PATIENT QUESTIONNAIRE

Please return completed questionnaire prior to your appointment, or bring with you to your appointment.

NAME_____ **BIRTHDATE**_____ **AGE**_____ **SEX**_____

APPT. DATE_____**REFERRED BY** _____**PRIMARY CARE**_____

Reason for visit:

- ❑ Environmental allergies
- ❑ Eczema/Atopic dermatitis
- ❑ Immunodeficiency
- ❑ Stinging insect allergy
- ❑ Other-please explain:
- ❑ Food allergy
- ❑ Hives/urticaria
- ❑ Cough
- ❑ Drug allergy
- ❑ Gastroesophageal reflux
- ❑ Asthma
- ❑ Angioedema
- ❑ Recurrent infections

CURRENT MEDICATIONS WITH DOSAGE (INCLUDING OVER THE COUNTER AND HERBAL SUPPLEMENTS)

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Have you used nasal sprays ❑ YES ❑ NO If yes, name: _____

Have you taken cortisone (steroids) topical and oral ❑ YES ❑ NO If yes, when? _____

Have you used antihistamines? ❑ YES ❑ NO If yes, name: _____

Have you had allergy shots in the past: ❑ YES ❑ NO

Do you have a nebulizer/aerosol machine? ❑ YES ❑ NO

Have you had lab tests or x-rays done related to your visit? ❑ YES ❑ NO If so, where? _____

LAB TESTS/X-RAYS	DATE

MEDICATIONS REACTIONS/ALLERGIES Please list any medication and reactions

Medication	Date taken	Reaction

SYMPTOMS: Do you experience any of the following: (Check each box that applies)

NOSE		SINUS		CHEST		SKIN	
Stuffy		Headache		Tightness		Rash	
Sneezing		Sore throat		Wheezing		Hives	
Itching/Rubbing nose		Post-nasal drainage		Wheezing exposure to dust, Pollen, animals		Eczema	
Clear/colorless discharge		Throat-clearing/sniffing		Wheezing with colds/infections		Swelling	
Thick/colored discharge		Hoarseness		Wheezing/coughing after Exercise		Itching	
Mouth-breathing		Bad breath		Shortness of breath		Sores	
Snoring		Frequent infections		Productive cough		What area?	
Loss/Decreased sense of smell				Dry cough			
Nosebleeds							

EYES		EARS	
Red		Itching	
Itchy		Full/Popping	
Watery		Painful	
Dark Circles		Ringing/Hearing loss	
Puffiness		Frequent infections	

TRIGGERS FOR YOUR SYMPTOMS

Are your symptoms ❑ Seasonal ❑ Year-round

During what months /seasons are your symptoms the worse? _____

Please check all of the following that seem to cause your symptoms to become worse

Mowing/Yard work		Weather change		Perfume		Morning	
Vacuuming/Dust		Wet weather		Chemical fumes		Afternoon	
Cedar		Dry weather		Smoke		Night	
Pollen		Windy days		Cleaning agents		Beer	
Mold or Mildew		Hot days		Newspaper		Wine	
Damp areas		Cold days		Indoors		Stress	
Dogs		Air-conditioning		Outdoors		Other (list):	
Cats		Air pollution		At home			
Other animals (list):				At work			

DURATION/SEVERITY OF SYMPTOMS

How long have symptoms been present? _____

Are symptoms ❑ Mild ❑ Moderate ❑ Severe ❑ Rare ❑ Frequent ❑ Constant
Interfering with life ❑ Yes ❑ No Preventing normal activities ❑ Yes ❑ No

FOOD REACTIONS Have you ever had any **systemic symptoms** (itching, hives, wheezing, shortness of breath, throat swelling, dizziness, fainting, shock) after ingesting a food or liquid? If yes, please list the food(s) and describe reaction:

_____

_____

Do you have **intestinal symptoms** (nausea, vomiting, cramps, pain, diarrhea) after ingestion of certain foods? If yes, specify _____

HOME ENVIRONMENT

Do you live in a: ❑ House ❑ Apartment ❑ Condominium ❑ Mobile Home ❑ One story ❑ Two story

How long have you lived there? _____years/months Age of home: _____years

Is it located on/near: ❑ Water ❑ Vacant land ❑ Industrial area ❑ Farm

Air conditioning: ❑ Central ❑ Window ❑ None Ceiling fans: ❑ Yes ❑ No

Type of flooring ❑ Carpet ❑ Wood ❑ Tile ❑ Vinyl ❑ Other
❑ Throughout ❑ In bedrooms ❑ Living room

How old is your mattress?_____ Type of mattress: ❑ Inner spring ❑ Water ❑ Allergy encasing

How old is your pillow?_____ Type of pillow: ❑ Feather ❑ Synthetic ❑ Foam ❑ Allergy encasing

Do you have pets? Yes No If yes, list the number and kind (dog, cat, bird, etc.)

_____

Are your allergy/asthma symptoms worse around your pets? ❑ Yes ❑ No

Do your pets live: ❑ Indoors ❑ Outdoors ❑ Both

Do your pets sleep in your bedroom? ❑ Yes ❑ No Do your pets sleep on your bed? ❑ Yes ❑ No

WORK ENVIRONMENT (as it applies to patient):

What is your occupation?_____Your employer?_____

How long have you worked there?_____Your environment is: ❑ Carpeted ❑ Tiled ❑ Other

Is it air conditioned? ❑ Yes ❑ No Is smoking permitted? ❑ Yes ❑ No

Are you exposed to chemicals or strong odors? Yes No If yes, please specify:_____

_____

Are your symptoms worse at work? ❑ Yes ❑ No If yes, please specify:_____

Have you missed time from work because of allergies/symptoms? ❑ Yes ❑ No If yes, how much time?:_____

Comments: _____

SCHOOL HISTORY/ENVIRONMENT : (as applies to patient)

Do you attend school? ❑ Yes ❑ No If yes, what grade level?_____

Is your classroom: ❑ Carpeted ❑ Tiled ❑ Other Any animals in your classroom? ❑ Yes ❑ No

Do you participate in physical education? ❑ Yes ❑ No

Have you missed school because of allergies/asthma? ❑ Yes ❑ No If yes, how many days last year?_____

Comments:_____

IMMUNE DEFICIENCY PATIENTS/CHRONIC INFECTIONS:

Infection History: Date/Age infections started? _____

Type of infections? ❑ Sinus ❑ Ear ❑ Abscess ❑ Pneumonia ❑ Skin ❑ Fungal

How were infections treated? _____

Was the treatment effective? _____

Were there labs or x-rays done related to the infections: ❑ Yes ❑ No If so, where? _____

Have you been on daily antibiotics or infusions (such as IgG) for this condition? ❑ Yes ❑ No

Any other symptoms related? Please describe _____

PAST MEDICAL HISTORY

Birth weight:_____ Born at term? ❑ Yes ❑ No If no, how early?_____

Problems with pregnancy /delivery?_____

LIST ANY SURGERIES/HOSPITALIZATIONS/MEDICAL CONDITIONS BELOW:	DATE

Are immunizations up-to-date? ❑ Yes ❑ No

Is growth normal? ❑ Yes ❑ No Is development normal? ❑ Yes ❑ No

If no, at what age level does patient function?_____

Do you smoke? ❑ Yes ❑ No If yes, when did you start?_____ How many cigarettes per day?_____

Have you ever smoked? ❑ Yes ❑ No If yes, how many years? _____When did you stop?_____

Average number of cigarettes smoked a day (when you smoked)?_____

Does anyone smoke in your home? ❑ Yes ❑ No If yes, who?_____

FAMILY HISTORY:

Check boxes below and list family members who have a history of any of the following illnesses/conditions:

		Family member			**Family member**
	Hay fever/allergy			Headaches	
	Asthma			Cancer	
	Eczema			Diabetes	
	Hives			High blood pressure	
	Swelling			Heart attack	
	Food allergy			Emphysema	
	Tuberculosis			Recurrent bronchitis/pneumonia	
	Autoimmune Disease			Immunodeficiency	

Any additional information we should know?

_____

_____

_____