

Everett Ear, Nose and Throat ALLERGY TESTING INSTRUCTIONS

Your allergy testing is scheduled for: _____ Everett office / Silverlake office

**Please note: We require 48 hour cancellation notice or you will be charged \$50.00.
Please call 425.258.4361 if you need to cancel this appointment.**

The following items are extremely important: PLEASE READ:

- Allergy skin testing takes approximately 1 (one) hour to complete.
- Please wear something short-sleeved or sleeveless.
- **DO NOT** take any antihistamines (for example: Allegra, Claritin, Zyrtec, Clarinex, etc.) for 48 hours prior to your skin testing appointment, including over the counter antihistamines, such as Benedryl or diphenhydramine or your appointment will be rescheduled.
- Be sure to eat something 1 hour before coming in for testing.
- Please do not wear any perfume, perfumed lotion or cologne to your testing appointment. In general, please avoid perfumes and colognes when visiting our office, as allergy sensitive people can be affected by these scents.
- Please make us aware of any medications that you are taking. Beta Blockers are often prescribed for hypertension, cardiac problems, eye problems and for migraines. If you are taking a Beta Blocker, please bring this to our attention.
- Asthma patients are advised to bring their inhalers to their testing appointment in case they feel the need to use them.
- If you are being re-tested, do not have your allergy shot within 5 days of your re-test.
- **BRING:** If you are on shots at home, please bring with you the documentation sheets, all of your vials (empty or expired) and a sample of the syringes that you are using to administer your shots.

Insurance: Allergy testing is covered by most insurance plans. You should contact your insurance to determine what your benefit is for *allergy* treatment.

VERY IMPORTANT:

Please complete IN FULL and bring with you the attached forms and the requested items to your appointment.

Thank you for your cooperation

ALLERGY TESTING QUESTIONNAIRE

Patient name: _____ Date of birth: _____

Do you have any of the following:

High blood pressure? Yes No
Asthma? Yes No If yes, are you using an inhaler? _____
Diabetes? Yes No
Pregnant or planning to be? Yes No
Other? Yes No Please
explain: _____

What is your worst season? (please circle) Spring / Summer / Fall / Winter / Year round

How long have you lived in this area? _____ Where did you live before? _____

Do you smoke? Yes No If you used to smoke, how long ago did you quit? _____

If you are a smoker, how many packs per day do you smoke? _____

Is there anyone in your household who smokes? Yes No

Have you ever been tested for allergies before? Yes No

If you have been tested, what did you test positive for? _____

If you were allergic did you ever have allergy shots or other treatment? _____

Do you have a family history of allergies? Yes No Asthma? Yes No Eczema? Yes No

Please check off the following if you have any of these symptoms:

<input type="checkbox"/> Post nasal drip	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Snoring
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Itchy Nose	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Watery Eyes
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Throat Clearing	<input type="checkbox"/> Cough
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Itchy Ears	<input type="checkbox"/> Ear pain
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Eczema	<input type="checkbox"/> Rash/Hives	<input type="checkbox"/> Itchy Skin
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Others _____		

Please list all of the medicines that you are currently taking. If possible, list the name and dose of the medicine. Attach a list if necessary.

_____	_____
_____	_____
_____	_____

Allergy testing questionnaire (continued)

Please answer the following questions to the best of your ability:

Type Of Home? _____ Age of Dwelling? _____ Age of the Carpet? _____

Do you have an Air Cleaner? _____ Type of Heating? _____ Type of Windows? _____

Age of Mattress? _____ Age of Pillows? _____ Feather/Down Bedding? _____

What is your occupation? _____

Do you have pets? Yes No

What type of pets do you have? Cat / dog / horse / cow / fish / other: _____

Are your pets: indoor / outdoor / both ?

Do your pets sleep in your bedroom? Yes No

How often do your pets get bathed? _____

Dietary Information:

Have you ever been tested for food allergies? Yes No

Do you suspect that you might have food allergies? _____

Do you avoid any foods for any reason? _____

Are you on a special diet? _____

Please use the following guide to determine how often you consume the following: (for example if you drink milk every day, place a "D" next to dairy)

(D) Daily	(W) Weekly	(M) Monthly	(R) Rarely	(N) Never	
___ Dairy	___ Corn	___ Tuna	___ Eggs	___ Citrus	___ Rice
___ Wheat	___ Chocolate	___ Potato	___ Nuts	___ Pork	___ Chicken
___ Soy	___ Beef	___ Fish	___ Peas	___ Beans	___ Fruit

How much Water do you drink each day? _____

How much Caffeine do you have each day? _____

How often do you consume Alcohol? _____

Is there anything else you would like us to know? _____
