

# ALLERGY TESTING INSTRUCTIONS

Everett Ear, Nose and Throat

Your allergy testing is scheduled for: \_\_\_\_\_  Evergreen  Silver Lake  
Date Time

**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.
- **VERY IMPORTANT** - **DO NOT** take any **antihistamines** for **48 hours prior** to your skin testing appointment. These medications will affect your test results. Your appointment will be rescheduled if you have taken any of these medications within 48 hours of the testing.  
A few common antihistamines are Allegra, Claritin, Zyrtec, Clarinex, or over the counter antihistamines such as Benadryl, Diphenhydramine (Sudafed), Tylenol PM, Advil PM, including many cold and cough medications. If you have questions about your medications consult your pharmacy.
- 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 the allergy staff aware of all 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 their attention.
- Asthma patients: please bring your inhaler to your appointment, in case you feel the need to use it.
- If you are being re-tested, do not have your allergy shot within 5 days of your re-test.
- **BRING:** If you do your 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.
- We ask that you **do not** bring your children (including infants), or if a minor is being tested, no siblings, as this is a distraction during testing. We do not have the facilities to care for children during testing.
- Pregnant patients or possibly pregnant patients **cannot** be tested.
- 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

Everett Ear, Nose and Throat

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.

_____	_____
_____	_____
_____	_____

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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? \_\_\_\_\_

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