Decatur ENT ASSOCIATES, P.C.

Medical And Surgical Specialists Of The Head & Neck

S. Kinney Copeland, M.D., F.A.C.S. George H. Godwin, M.D., F.A.C.S. Ben Light, M.D. F.A.C.S.

INSTRUCTIONS FOR ALLERGY TESTING

Please make use aware of any medications that you are taking. Do not take antihistamines for 3 days prior to your skin testing appointment.

Please let us know if you are taking a *beta-blocker. Beta-blockers are often prescribed for hypertension, cardiac problems, eye problems and for migraines. Please bring this to our attention.

Your will be given allergy history questionnaire to complete and return on the day you are tested. Please take the time to fill this out the best you can. We would also like you to keep a diet diary for at least 7 days.

Allergy skin testing takes about 1 hour to complete. Please wear something short sleeved or sleeveless.

If you are testing using in-vitro methods, plan on only a short office visit to obtain a sample of blood. Further skin testing may be warranted depending upon the results of the blood test. You will be contacted by phone with the results of the blood test.

If you have any questions before your appointment, please do not hesitate to contact me.

Your allergy testing is scheduled for _____.

Allergy Specialist

Penny Buckelew
MLT/ASCP

*Cartol (Carteolol HCI), Corguard, Corzide (Naldolo), Bets Pace (Sotalol), Levatol, (Penbutolol), Visken (Pindolol), Inderal, Inderide LA (Propranolol), Blocadren (Timolol), Tenormin, Tenoretic (Atenolol), Brevibloc Injection (Esmolol), Lopressor (Metolprolol), Sectral (Acebutolol), Trandate+ HCT, Normodyne, Normozide (Ladetolol), Kerlone, Betoptic (Betaxolol), Betagan Liquifilm (Levobumolol), and Timoptic, Timolide (Timolol) and Ocupress (Carteolol), Zebeta, Tropral XL.

I have read and understand the above instructions on allergy testing and any questions regarding my testing have been answered to my satisfaction.

_____ _____

Patient Date

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FOOD ALLERGY - NUTRITIONAL QUESTIONNAIRE

Name_____ Date_____

PLEASE READ EACH QUESTION CAREFULLY. Then circle Yes or No to indicate your answer. If yes—please explain.

Yes No 1. Are there any foods or beverages that you a) crave or b) eat frequently? List:

a) _____ b) _____

_____ _____

_____ _____

Yes No 2. Are there any foods or beverages that you dislike? List:

_____ _____ _____ _____

Yes No 3. Are you awakened between the hours of 1:00 a.m. and 5:00 a.m. with the following symptoms: headache, dizziness, stomach cramps, bloating, or dry cough? (Circle which)

Yes No 4. Do you or any member of your family have hayfever, asthma, hives, chronic skin condition, migraine headaches, or colitis? (Circle which)

Yes No 5. During childhood did you have any of the following: Eczema, hayfever, asthma, food feeding problems? (Circle which)

Yes No 6. Do you ever have itching of the skin, palate or roof of your mouth or skin rash? (Circle which)

Yes No 7. Do you frequently notice swelling of your ankles, feet, hands, or face? (Circle which)

Yes No 8. Do you have marked fatigue two to three hours after meals?

Yes No 9. Do you eat snacks frequently between meals? List examples.

_____ _____ _____ _____

Yes No 10. Do you have excessive chilling when a sudden change in temperature occurs?

Yes No 11. Do you have frequent headaches or "Migraine?"

Yes No 12. Do you experience belching, abdominal distention, bloating or cramps following meals?

Yes No 13. Have you noticed numbness of the face, arms, or legs at periodic intervals for no apparent cause?

Yes No 14. Do you have drowsiness, headache or bloating following the ingestion of a cocktail, glass of beer or glass or wine? (Circle which)

Yes No 15. Do you have alternating constipation and diarrhea?

Yes No 16. Do you have joint or muscle pain or stiffness?

Yes No 17. Do you have fluctuating vision?

Yes No 18. Do you have recurring fungal infections (vaginitis, athlete's foot, jock itch, or ring worm)?

Yes No 19. Do you have fluctuating ringing in the ears or dizziness?

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INSTRUCTIONS FOR KEEPING YOUR 1 WEEK FOOD DIARY

1. Please note the time of day for each meal and snack.

2. Note <u>everything</u> you eat during this 1 week period (including gum, mints and beverages.)

3. Note all medications taken in the proper space with the time they were taken.

4. If you add something to a food please note it; example: cream/sugar/sweetener in coffee, butter and/or jelly on toast.

5. Note symptoms when they occur and/or change. The following may help you evaluate how you feel.

    a. General Symptoms: Are you tired, nervous, depressed? Or are you happy and alert? Do you feel you can't concentrate? Do you feel too drowsy to work?
    b. Head – Eye and Ear Symptoms: Does your head ache? Does it feel tight or full? Does it throb? Do your eyes burn, itch or tingle? Do your ears pop, buzz or feel stopped up.
    c. Nose and Throat Symptoms: Is your nose stuffy or runny? Are you sneezing? Does your nose itch>? Do you feel extra postnasal drainage? Does your nose feel blocked? Does your throat tickle, itch or feel sore?
    d. Chest Symptoms: Does your chest feel tight? Are you coughing or wheezing? Are you conscious of your heart beat? Is it beating faster than usual?
    e. Digestive Symptoms: Does your stomach burn or ache? Do you feel bloated? Are you burping or passing extra gas? Are your intestines growling? Are your stools loose? Are you constipated?
    f. Skin, Muscle and Miscellaneous Symptoms: Do you have a rash or itching? Do you have leg ache, backache, or aching in any other muscles? Do you feel puffy? Do you have urinary frequency? Bladder problems? Bedwetting?

Please bring your complete food diary with you on the day of your allergy test or as instructed by the allergy nurse.

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7 DAY DIET DIARY

Patient's Name: _____ **Date:** _____

1ST DAY	2ND DAY	3RD DAY	4TH DAY	5TH DAY	6TH DAY	7TH DAY
Breakfast						
Symptoms						
Medication						
Luncheon						
Symptoms						
Medication						
Dinner						
Symptoms						
Medication						

1218 13th Avenue SE, Decatur, AL 35601 • Phone 256.355.6200 • Fax 256.355.6241

ALLERGY HISTORY

Date: _____

Patient's Name: _____ Sex: _____ Age: _____
Last First Initial

Street _____ City _____ State _____ Zip _____

Home Telephone No. _____ Parent's Name _____
Area Code Number Last First Initial

To be filled out by patient Your answers to the following questions will help to determine the cause of your allergy symptoms. It is important to check (✓) each question as accurately as possible.

	YES	NO	Don't Know
Have trouble with your skin?			
Eczema			
Hives			

	YES	NO	Don't Know
Have trouble with your ears?			
Popping			
Itching			
Hearing loss			
Fluid in ears			
Infection/Pain			

	YES	NO	Don't Know
Have trouble with your throat?			
Frequently sore/drainage			
Itching throat/mouth			

	YES	NO	Don't Know
Have trouble with your eyes?			
Redness			
Itching			
Tearing			
Puffiness			

	YES	NO	Don't Know
Have trouble with your nose?			
Clear/colorless discharge			
Thick/colored discharge			
Nasal itching/rubbing			
Constant stuffiness			
Periodic stuffiness			
Sniffles			
Sneezing			
Mouth breathing or snoring			

	YES	NO	Don't Know
Have troubles with your chest?			
Wheezing with colds			
Wheezing when exposed to dust, pollen, animal, etc.			
Wheeze/cough/after exercise			
Cough? What kind?			
Deep/or productive			
Loose			
Constant			
Dry/tight			
Daytime			
Nighttime			

	YES	NO	Don't Know
Are your symptoms mild?			
Moderate			
Severe			
Present most of the time			
Present part of the time			
Present rarely			
Interfering with your life			
Preventing many normal activities			

Which of the following do you think cause your symptoms or make them worse?	YES	NO	Don't Know
Indoors			
Outdoors			
At home			
At work			
Morning			
Afternoon			
At night			
Weather change			
Wet weather			
Dry weather			
Windy day			
Hot day			
Cold day			
Air conditioning			
In barns			
Damp areas			
Hay, circus			
Mowing lawn			
Dusty environment			
High air pollution			
Animals			
Cooking odors			
Smoke			
Soap powder			
Insecticides			
Paint fumes			
Perfumes			
Cosmetics			
Wave sets			
Newspapers			
Wool			
Road dust			
Milk or milk products			
Eggs			
Wheat products			
Nuts, beans, or seeds			
Chocolate			
Fish			
Meat			
Fruit			
Vegetables			
Alcoholic beverages			
Cheese, mushrooms			
Beer			
Wine			
Aspirin			
Chemicals (list):			
_____			
_____			
Drugs (list):			
_____			
_____			

During what months do you usually have symptoms?	YES	NO	Don't Know
All months			
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Describe what symptoms bother you most
_____
_____

When did your condition begin?
_____

	YES	NO	Don't Know
Do you use medication regularly for nasal symptoms?			
What medication? _____			
Does it help?			

	YES	NO	Don't Know
Do any of your blood relatives have allergies?			
Have you ever had skin tests for allergies?			
Do you have allergies?			

What are you allergic to?
_____
_____

	YES	NO	Don't Know
Is there anything else about your problem which you think might be important or unusual?			

_____
_____
_____
_____

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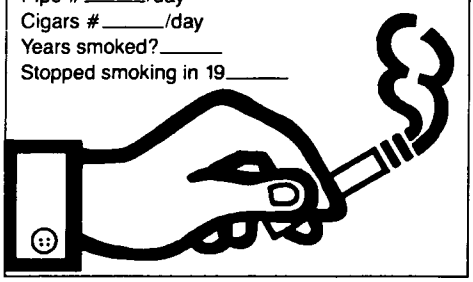
Phone 256.355.6200

	YES	NO	Don't Know
Smokers in your home?			
Do you smoke?			

Cigarettes #_____/day
Pipe #_____/day
Cigars #_____/day
Years smoked?_____
Stopped smoking in 19_____



Do you take medications daily or frequently?			
Aspirin			
Cortisone			
Laxatives			
Sedatives			
Birth control pills			
Vitamins			
Ointments			
Nose drops/sprays			
Hormones			
Others (list):			

_____
_____

Do you spend a good deal of time in activities?			
Photography			
Carpentry			
Camping			
Sewing			
Gardening			
Painting			
Cooking			
Movies			
Hobbies (list):			

_____

Sports (list):			

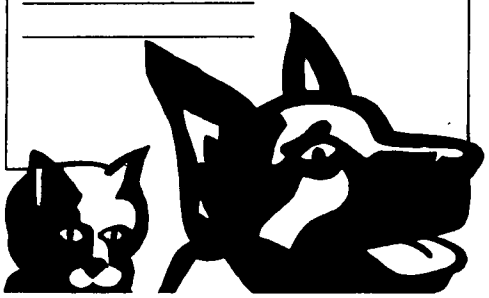
_____

Other (list):			

_____

Do you have animals in your home?			
Have you ever had animals in your home?			
Dog			
Cat			
Bird			
Rodent			
Other (list):			

_____
_____



	YES	NO	Don't Know
Do you live in: House?			
Apartment?			
In the city?			
In the suburbs?			
Is your dwelling: New?			
3–10 years old?			
11–25 years old?			
> 25 years old?			

Have you had any of the following?			
High blood pressure			
Migraine headaches			
Skin disease			
Heart disease			
Frequent headaches			
Sinus disease			
Stomach disease			
Asthma			
Nasal polyps			
Emphysema			
Broken nose			
Overactive thyroid			
Bronchitis			
Nasal surgery			
Underactive thyroid			
Hay fever			
Deviated septum			
Hormonal difficulty			
Hives			
Food allergy			
Drug allergy (describe):			

_____
_____

Other conditions (describe):			

_____
_____

Are you taking medication for any of the previous conditions? (describe):			

_____
_____

Do you think your occupation has anything to do with your symptoms?			

Describe your occupation:

_____
_____

Are any materials used in your occupation that you think have something to do with your condition? (describe):			

_____
_____
_____

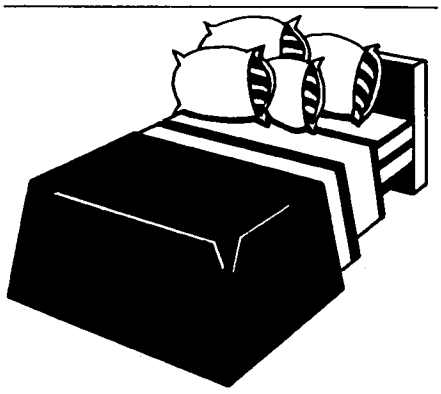
At work, are your symptoms better?			
Worse			
The same			

	YES	NO	Don't Know
Do you sleep with a pillow?			
Is it dacron?			
Is it foam rubber?			
Is it feather?			
Other (describe):			

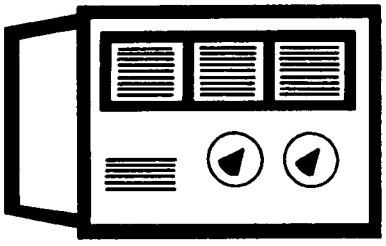
_____

Is your mattress cotton?			
Feather			
Foam rubber			
Horse hair			
Other (describe):			

_____



Do you use a humidifier?			
Do you have an air conditioner?			
At work			
At home			
In bedroom			
Central			



Is your heating system oil?			
Gas			
Coal			
Electric			
Other (describe)			

_____
_____

Is heat delivered by blower?			
Radiators			
Electric panels			
Other (describe)			

_____
_____

Initial_____

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ALLERGY TESTING - INSURANCE INFORMATION

Our office does mainly Intradermal allergy testing, otherwise known as skin testing. On some occasions we will do RAST allergy testing which is a blood test and Percutaneous allergy testing which is a multi-puncture test. If there are borderline reactions, a second series of tests may be necessary.

Each insurance company and insurance policy has different benefits for this testing and treatment. Our office will check your insurance coverage for filing and billing purposes, but we suggest each patient verify this coverage with their insurance company also. Anything not covered by your insurance company will be due from you at the time of service. We will file all your services with your insurance. Any overpayment will be refunded as soon as all insurance claims are resolved. Listed below are some important questions, procedure codes and prices for you and your insurance company:

1. Is allergy testing covered under my policy?
2. Are there any deductibles or co-pays required?
3. Are there any limits to the amount covered?
4. Procedure Codes and Prices

86003 RAST - Billed by outside lab, prices _____ and up
95004 Percutaneous _____ per antigen. We will do _____ at a cost of _____
95024 Intradermal _____ per antigen. We will do _____ at a cost of _____

95115 Injection _____
95117 Injections _____
95165 Vial _____

Our insurance coordinator, Patricia Copeland, will be contacting you either by mail or phone. If you have not been contacted prior to your test date, please give her a call at 355-6200, in order to know what is required from you on the day of your testing.

I have read and understand all the above information.

_____ _____

Patient Date