ANTHONY J. BARONE MD

Ears,Nose & Throat
Allergy
Hearing/Balance
Voice Evaluation

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WELCOME TO THE ALLERGY DEPARTMENT

In this allergy packet you will find a questionnaire and a 14-day food diary. Both forms should be completed and brought with you on the day of your test.

1. CHARGES

Contact your insurance carrier prior to the allergy test to determine if you will have any co-payments for this test or future allergy shots. The codes are as follows: Testing 95027, Vials 95165, Allergy shots 95117. The vial charge and shot expense will start only if you decide to start desensitization.

2. MEDICATIONS

There are certain medications that you must not take prior to testing. These will cause false negative readings. All antihistamines, decongestants, over the counter nasal sprays, cough medicines, stomach medications, sleeping pills. Please see page 2 for complete listings and recommended pause length.

Be sure to take medications prescribed for diabetes, high blood pressure, cardiac and thyroid problems. These medications will not interfere with the test.
If there are any questions, contact the allergy nurses at (401) 944-6552 ext.104

3. ATTIRE

We test on the upper arm area. A sleeveless or short sleeve shirt which can be rolled above the shoulder should be worn. Please do not wear perfume or aftershave on the day of your test. You may wear deodorant.

4. APPOINTMENTS

You are given a specific test time. If you are going to be late, please call ahead to see if we can still accommodate you. **We require 24 hour notice on all cancelations or you will be charged a $100 fee.**

5. You cannot receive allergy testing:

a. If you have received an allergy shot within the last 2 weeks
b. If you had a fever within the last 48 hours
c. If you have shingles, poison ivy, hives or any other skin rash

Fasting before exam is not necessary. Refer to page 2 for dietary supplements to avoid before test.

Due to safety concerns children should not accompany parents to their test unless there is another adult to supervise them. Children will not be allowed in testing area.

Vigorous exercise or weight lifting should be avoided on test and allergy shot days.

MEDICATIONS TO AVOID BEFORE ALLERGY TESTING

OFF 1-2 WEEKS BEFORE TESTING: With written permission from your prescribing doctor faxed to this office (401-943-2379)

Amitriptyline (Elavil)	Clomipramine (Anafranil)
Doxepin (Sinequan)	Imipramine (Tofranil)
Trimipramine (Surmontil)	Amoxapine(Asendin)
Desipramine(Nurpramin)	Nurtriptyline (Pamelor,Aventyl)
Protriptyline(Vivactil)	Maprotiline(Ludiomil)
Mirtazapine(Remeron)	Trazadone(Desyrel)
Nefazadone(Serzone)	Allergy Shots
Compazine	

OFF 4 DAYS BEFORE TESTING: With written permission from your prescribing doctor faxed to this office(401-943-2379)

Beta Blockers (Blood Pressure)

OFF 5 DAYS BEFORE TESTING

Clarinex (Desloratadine)	Alavert (Loratadine)
Zyrtec (Cetirizine)	Xyzal (Levocetirizine)
Claritin (Loratadine)	

OFF 4 DAYS BEFORE TESTING

Antihistamines	
Axid	Cosogt (eye drops)
Tagamet	Famotidine
Pepcid	Zantac

OFF 4 DAYS BEFORE TESTING
Herbal Supplements

Licorice		Green Tea
Saw Plametto		St.John's Wort
Feverfew	Milk Thistle	Astragalus

3 DAYS BEFORE TEST

Singulair (Montelukast)	Bromfenex
Allegra (Fexofenadine)	Bromfed PD
Dymista Nasal Spray	Benedryl
Astelin Nasal Spray	

Allergy Specialists OF KNOXVILLE, PLLC
www.AllergySpecialistsofKnoxville.com

Medications That Do Not Interfere with Allergy Skin Testing

The following medications listed below **DO NOT** interfere with skin testing and may be continued up until your allergy appointment. (This list is not all inclusive, but it does include some of the more common medications that our new patients may be taking.)

Decongestants: Sudafed ®, pseudoephedrine, phenylpropanolamine

Leukotriene Inhibitors: Singulair ®, Accolate ®, Zyflo ®

Corticosteroids: prednisone, prednisolone, methylprednisolone, Medrol ®, Orapred ®

Corticosteroid Nose Sprays: Nasonex®, Nasacort AQ®, Omnaris®, fluticasone, Flonase®, Veramyst® Rhinocort Aqua ®

Expectorants: Mucinex ®, guiafenesin

Cough suppressants: Delsym ®, dextromethorphan

Asthma inhalers and all nebulized asthma medications: all are OK – please do not stop them for testing

Reflux medications: Protonix ®, Prevacid ®, Aciphex ®, Nexium ® , Prilosec ®, omeprazole

Other medications that do not affect skin testing include:

Antibiotics	Anticonvulsant medications
Arthritis medications	Birth control pills and female hormones
Cardiac medications	Cholesterol medications
Diabetes medications	Eye drops used for glaucoma, steroid eye drops
Thyroid medications	

Most medications for hypertension (high blood pressure) including: Norvasc ®, amlodipine, Cardizem ®, diltiazem, felodipine, Cardene ®, nicardipine, Procardia ®, nifedipine, nisoldipine, Calan ®, Veralan ®, verapamil, Lotensin ®, benazepril, Atacand®, candesartan, Capoten ®, captopril, Vasotec®, enalapril, Monopril ®, fosinopril, Avapro ®, irbesartan, Cozaar ®, losartan, Benicar ®, olmesartan, Accupril ®, quinapril, Micardis ®, telmisartan, Diovan ®, valsartan. **If you are taking a BETA BLOCKER, please tell our receptionist when scheduling your appointment.**

Most medications for insomnia and depression including: Ambien, zolpedem, Lunesta, Xanax, alprazolam, Ativan, lorazepam, Valium, diazepam, Prozac, fluoxetine, Effexor, venlafaxine, Zoloft, sertraline, Celexa, citalopram, Lexapro, escitalopram, Wellbutrin, bupropion, Paxil, paroxetine, Cymbalta, duloxetine.

ME

HAVE YOU EVER BEEN SKIN TESTED BEFORE?

☐ - Yes
☐ - No
☐ - Don't know

If ves, when? _____
What were the results? _____
Did you have injections? _____ How long? _____

DO ANY OF YOUR BLOOD RELATIVES HAVE ALLERGIES?

☐ - Yes If yes, specify.
☐ - No
☐ - Don't know

CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE HAD.

☐ - High blood pressure
☐ - Heart disease
☐ - Stomach or intestinal disease
☐ - Overactive thyroid
☐ - Underactive thyroid
☐ - Hormonal difficulty
☐ - Migraine headaches
☐ - Frequent headaches.
☐ - Athlete's foot
☐ - Other

☐ - Asthma
☐ - Emphysema
☐ - Bronchitis
☐ - Hay fever
☐ - Hives
☐ - Skin disease
☐ - Sinus disease
☐ - Nasal polyps
☐ - Broken nose
☐ - Nasal Surgery
☐ - Deviated septum

☐ Drug allergy
What drugs? _____

☐ Food allergy
What foods? _____

DURING WHAT MONTHS DO YOU USUALLY HAVE SYMPTOMS?

☐ - all months

☐ - January
☐ - February
☐ - March
☐ - April
☐ - May
☐ - June

☐ - July
☐ - August
☐ - September
☐ - October
☐ - November
☐ - December

Which months are worse?

SOME OF FOLLOWING MAY CAUSE SYMPTOMS OR MAKE THEM WORSE. CHECK THOSE THAT DO.

☐ - in-doors
☐ - out-doors
☐ - 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 pollution day

☐ - animals
☐ - cooking odors
☐ - smoke
☐ - soap powder
☐ - insecticides
☐ - paint fumes
☐ - perfumes
☐ - cosmetics
☐ - wave sets
☐ - newspapers
☐ - wool
☐ - road dust
☐ - chemicals (list)

ANIMALS IN HOME:

in past	at present
☐ - Dog	☐ - Dog
☐ - Cat	☐ - Cat
☐ - Bird	☐ - Bird
☐ - Rodent	☐ - Rodent
☐ - Other	☐ - Other

Other animals you frequently contact:

WHAT MEDICATIONS DO YOU TAKE DAILY OR FREQUENTLY?

☐ - Aspirin
☐ - Cortisone
☐ - Antihistamines
☐ - Decongestants
☐ - Nose drops

☐ - High B.P. medication
☐ - Diuretics
☐ - Hormones
☐ - Birth control pills
☐ - Vitamins
☐ - Ointments
☐ - Other

List medications presently being taken or have taken in past year.

CHECK THE SYMPTOMS YOU ARE HAVING OR USUALLY HAVE.

☐ - Itchy nose
☐ - Stuffy nose
☐ - Runny nose
☐ - Sneezing
☐ - Post nasal drip
☐ - Loss of smell
☐ - Itchy eyes
☐ - Watering eyes

☐ - Itchy throat
☐ - Sore throat
☐ - Hoarseness
☐ - Cough
☐ - Wheeze
☐ - Blocked ears
☐ - Itchy ears
☐ - Rash

ARE SYMPTOMS:

☐ - Constant
☐ - Eratic
☐ - Present most of time
☐ - Present part of time
☐ - Present rarely

ARE SYMPTOMS WORSE:

☐ - Morning
☐ - Afternoon
☐ - Evening
☐ - Night

☐ - At home
☐ - At work
☐ - Other location

DO YOU USE A HUMIDIFIER?

☐ - Room
☐ - Central

DO YOU USE A DEHUMIDIFIER?

☐ - Yes
☐ - No

AIR CONDITIONING:

☐ - Bedroom
☐ - Central
☐ - None
☐ - Work

PILLOW:

☐ - None Used
☐ - Feather
☐ - Foam
☐ - Dacron
☐ - Other

HEATING SYSTEM.

☐ - Oil
☐ - Gas
☐ - Coal
☐ - Wood
☐ - Electricity
☐ - Hot air
☐ - Radiators (steam)
☐ - Forced hot water
☐ - Electric panels
☐ - Space heaters
☐ - Wood stove

☐ - milk or milk products
☐ - eggs
☐ - wheat products
☐ - nuts, beans, or seeds
☐ - chocolate
☐ - fish
☐ - meat
☐ - fruit
☐ - vegetables
☐ - alcoholic beverages
☐ - beer
☐ - wine
☐ - cheese, mushrooms
☐ - aspirin
☐ - drugs (list)

ENVIRONMENT:

Occupation: _____

Prominent materials used: _____

Home ☐ - house ☐ - apartment

☐ - City
☐ - Wooded area
☐ - Near water
☐ - Near fields

SMOKING HABITS:

Cigarettes #____/day
Pipe #____/day
Cigars #____/day
Years smoked: _____
Stopped smoking in 19____
Does any other member of family smoke?

List hobbies and materials used:

C/CP 119538

ANTHONY J. BARONE, M.D

PATIENT HEALTH UPDATE FORM

Patient Name:_____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____ Work:_____

In Case of Emergency – Name: _____ Relationship: _____ Telephone: _____

Email address: _____

MEDICAL HISTORY: *Please check off health conditions for which you are being treated or take medication for:*

__High Blood Pressure	__Bleeding Problems	__Arthritis	__Psychiatric Problems	__Cancer
__High Cholesterol	__Heart Disease	__Liver Problems	__Back/Neck Pain	__Diabetes
__Tuberculosis	__Kidney Problems	__Osteoporosis	__HIV/AIDS	__Asthma
__Stomach Ulcer	__Heart Attack	__Blood Clots	__COPD/Emphysema	__Anemia
__Thyroid Problems	__Vascular Problems	__Seizures/Epilepsy	__Stroke	

MAJOR SURGERIES SINCE YOUR LAST VISIT: *(Please list procedure and year)*

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS: (*Please list all current medications – **include over the counter** - or provide a list for us to copy and attach)*
*If you do not take any medication, **please circle** -* **I TAKE NO MEDICATION**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ARE YOU ALLERGIC TO ANY MEDICATION(S): _____ *If NONE, **please circle:*** **NKDA**

Do you smoke tobacco? Yes/No/Quit How many packs per day? _____For how many years: _____
Do you drink alcohol? Yes/No Frequency/Quantity: _____

PLEASE CHECK ANY SYMPTOMS YOU *ARE EXPERIENCING AT THIS TIME*: *(Review of Systems)*

CONSTITUTIONAL:	__Fever	__Chills	__Night Sweats	__Sudden Weight Gain/Loss	
NEUROLOGICAL:	__Headache	__Dizziness	__Fainting		
EYES:	__Eye Pain	__Vision Changes	__Tearing/Itchy Eyes		
ENT:	__Hearing Loss	__Ear Pain	__Ear Discharge	__Ringing in Ears	__Nasal Congestion
	__Runny Nose	__Nasal Bleeding	__Hoarseness	__Difficulty Swallowing	__Sore Throat
NECK:	__Swollen Glands	__Neck Mass/Lump			
CARDIOVASCULAR:	__Chest Pain	__Palpitations			
PULMONARY:	__Cough	__Wheeze	__Shortness of Breath		
GASTROINTESTINAL:	__Abdominal Pain	__Nausea	__Vomiting		
SKIN:	__Rash	__Unexplained Bruising			
PSYCHIATRIC:	__Intent to Harm Self				

FAMILY HISTORY: **HAVE MEMBERS OF YOUR FAMILY EXPERIENCED ANY OF THE FOLLOWING?** *(Circle all that apply):*

Environmental Allergies	Sinus Problems	Chronic Headaches	Head/Neck/Throat Cancer
Hearing Loss	Sleep Apnea	Vertigo/Dizziness	Bleeding Problems

PATIENT SIGNATURE: _____ **DATE:** _____

Patient's Name _____ **14 DAY DIET DIARY** Date _____

DIET DIARY

1st Day	2nd Day	3rd Day	4th Day	5th Day	6th Day	7th Day
BREAKFAST						
Symptoms						
Medication						
LUNCHEON						
Symptoms						
Medication						
DINNER						
Symptoms						
Medication						

CP 119505

(OVER)

8th Day	9th Day	10th Day	11th Day	12th Day	13th Day	14th Day
BREAKFAST						
Symptoms						
Medication						
LUNCHEON						
Symptoms						
Medication						
DINNER						
Symptoms						
Medication						