THE ALLERGY GROUP OF SOUTHERN CALIFORNIA

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Pediatric and Adult Allergy Immunology

Allergy Review

Name:___________________________ **Date of Birth**:________________ **Today's Date**:__________________

Primary Physician:______________________ **Phone**:__________________ **Referred By**:__________________

Please describe the primary reason(s) for pursuing an Allergy Consultation:_______________________________

____

____

SYMPTOM REVIEW (Please check or fill in all that apply):

NOSE: ☐ runny ☐ stuffy ☐ sneeze ☐ itchy ☐ dryness
☐ pain ☐ sinusitis ☐ polyps ☐ bleeding ☐ type of surgery:_______________
☐ loss of smell ☐ surgery ☐ itchy ☐ rubbing _______________

LUNGS: ☐ wheezing ☐ tightness ☐ coughing ☐ pneumonia ☐ croup
☐ deep sighing ☐ exercise limitation ☐ nighttime awakening

SKIN: ☐ eczema ☐ hives ☐ swelling ☐ contact dermatitis
☐ location of eczema:_______________________________________

EYES: ☐ itching ☐ burning ☐ swelling ☐ redness ☐ dryness
☐ tearing ☐ discharge

EARS: ☐ itching ☐ blocked ☐ popping ☐ ringing ☐ deafness
☐ PE tubes ☐ infection ☐ # of infections within past 12 months:_______________

MOUTH and THROAT: ☐ soreness ☐ itching ☐ clearing ☐ postnasal drip
☐ tightness ☐ hoarseness ☐ loss of taste ☐ delayed speech

GI: ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation
☐ cramps ☐ pain ☐ gas ☐ bleeding

SLEEP: ☐ snoring ☐ mouth open ☐ restless ☐ frequent awakening

HEADACHE: ☐ frontal ☐ temples ☐ neck ☐ eye
☐ nausea ☐ tooth pain ☐ blurred vision ☐ numbness

ADDITIONAL ALLERGIC HISTORY

Adverse reactions to medications / foods / insect bites / jewelry:_____________________________________

____

____

Previous skin testing, pulmonary function testing or allergy shots:_____________________________________

____

____

Current / recent medications (include name, dose, frequency and duration of use):__________________________

____

____

____

(continued on page 2)

(continued from page 1)

EXACERBATING FACTORS (Please check items which worsen symptoms):

□ spring	□ morning	□ heat	□ perfumes
□ summer	□ afternoon	□ air conditioning	□ paints
□ fall	□ evening	□ dog	□ sprays
□ winter	□ early morning	□ cat	□ home
□ rain	□ night	□ horse	□ car
□ wind	□ smog	□ rabbit	□ ________________
□ cold	□ outdoors	□ smoke	□ ________________

ENVIRONMENTAL SURVEY

In what city do you live? ________________ How long have you lived there?________________

AIR CONDITIONING: □ central □ swamp □ room unit
□ filter □ frequency filter is changed/cleaned:________________

AIR QUALITY: □ smokers □ sprays □ odors □ humidifiers
□ air filter □ type:________________

HEATING: □ central □ radiator □ room unit □ space unit
□ frequency of furnace cleaned:________________

PETS: □ cat □ dog □ horse □ birds □ other________
□ bedroom access □ location of kitty litter (if any)________________

BED: □ frame bed □ waterbed □ futon □ bunk bed (top/bottom)
□ crib □ allergy encasement

BLANKETS: □ cotton □ synthetic □ down

PILLOWS: □ foam □ synthetic □ down □ allergy encasement

WINDOWS: □ drapes □ mini-blinds □ shades □ verticals □ shades
□ frequency cleaned:________________

FLOORING: □ carpet □ wood □ tile □ vinyl
□ recent carpet cleaning □ frequency of vacuuming:________________

DUSTS: □ shelves □ plants □ stuffed animals
□ frequency of dusting:________________

MOLDS: □ mildew □ leaf piles □ water damage

PAST MEDICAL HISTORY

Medical and Surgical History:________________

____

Family History of Illnesses (include allergies)________________

____

Dietary Habits________________

Tobacco Use________________ Alcohol Use________________

Other Drug Use________________ Hobbies________________

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Allergy Consultation and Skin Testing

Thank you for scheduling an Allergy Consultation! We will do our best to take care of you and to help treat your allergic symptoms. There are a few things we'd like you know before your appointment, including information about medications you will need to avoid if we are to do allergy skin testing.

As part of your consultation, we might recommend skin testing to help identify your allergenic triggers. Skin testing uses allergic antibodies already in your skin to create localized allergic reactions that can then be measured. This will enable us to advise you on how to avoid environmental or food triggers. If allergy shots are necessary, skin testing is essential to creating the right serum for you.

How is skin testing performed?

Purified extracts of common allergens are placed onto plastic prongs that are then gently pressed into the skin. If you are allergic, redness, itching and swelling may occur at the site and reactions can then be measured. This usually takes twenty (20) minutes. In some circumstances it may be necessary to do an additional test using a needle and syringe to inject material underneath the skin.

What are the side effects of skin testing?

The most common side effect is itching and swelling at the site of a positive reaction. We will place a steroid cream on the skin to alleviate these symptoms but the reactions could last as long as twenty-four (24) hours. Occasionally, skin testing may also exacerbate already existing allergic problems, such as hay fever, asthma or eczema. Please let us know immediately if you having a serious reaction following skin testing.

What do positive reactions mean?

Positive skin tests identify allergic antibodies. Whether or not they identify what is causing your symptoms depends upon numerous factors, including the amount of exposure and your level of sensitivity. Once skin testing has been completed, your doctor will review your testing in the context of your history, physical exam and environment before designing a comprehensive plan for you.

Which medications do I avoid before skin testing?

Antihistamines may interfere with skin testing and should be avoided for ten (10) days prior to the appointment. Nasal sprays and inhaled medications will not interfere and should not be discontinued.

Should you have any questions between now and the time of your appointment, please feel free to contact the office.