TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER™

DIVISION OF ALLERGY AND IMMUNOLOGY

To ensure your skin test is accurate, it is very important that you avoid taking any antihistamines for at least 5 days prior to your appointment. A list of medications containing antihistamines is provided below. Ask your pharmacist or call us if you have questions about other medications.

DO NOT STOP ANY OTHER MEDICATION unless advised. If you have any questions about medications that you are taking, please call us at 806-743-3150.

If included, please complete the enclosed "Release of Information" form as well as this patient history and bring them with you on the day of your appointment.

Medications to Avoid Prior to Allergy Skin Tests for at Least 5 Days

ANTIDEPRESSANTS WITH PROPERTIES LIKE ANTIHISTAMINES - DO NOT TAKE FOR AT LEAST 5 DAYS

Amitriptyline (Elavil, Trytpomer, Triavil)	Desipramine (Norpramin)	Nortriptyline (Pamelor)	Quetiapine (Seroquel)
Amoxapine (Asendin)	Doxepin (Sinequan)	Protriptyline (Vivactil)	Trimipramine (Surmontil)
Clomipramine (Anafranil)			Trazadone (Oleptro)

ANTIHISTAMINES- NON-PRESCRIPTION - DO NOT TAKE FOR AT LEAST 5 DAYS

Actifed	Comtrex	PediaCare	Tylenol Flu Night Time
Alka Seltzer Plus Sinus Allergy Med	Coricidin	PediaCare Cold Allergy	Vicks NyQuil Formula 44
Allegra, Allegra D	Dimetapp	Pepcid AC	Tylenol PM
Allerest	Dristan Allergy & Cold	Sine-Aid	Vicks Pediatric 44M
BC Cold Powder Multi-Symptom	Drixoral	Sudafed Plus	Xyzal
Benadryl	Fexofenadine	Tagamet	Zyrtec
Cetirizine	Isoclor	Tavist 1 & D	
Chlor-Trimeton	Levocetirizine	Tylenol Allergy Sinus	
Claritin, Claritin D, Clarinex	Loratadine, Desloratadine	Tylenol Cold Multi-Symptom	

ANTIHISTAMINES- PRESCRIPTION - DO NOT TAKE FOR AT LEAST 5 DAYS

Actifed with Codeine	Dimetane	Nolahist	Semprex-D
Atarax	Extendryl	Phenergan	Sinulin
Atrohist	Fedahist	Ricobid	Trinalin
Bromfed	Hydroxyzine	Rondec	Tussionex
Comhist	Kronofed	Ru-Tuss	Vistaril
Deconamine	Marax	Rynatuss	

DO NOT STOP Medicines to Reduce Stomach Acid

ANTIHISTAMINES TO REDUCE STOMACH ACID – DO NOT STOP TAKING

Pepcid (famotidine)	Tagamet (cimetidine)	Zantac (ranitidine)

NASAL SPRAY - DO NOT TAKE FOR AT LEAST 2 DAYS

Astelin	Astepro	Patanase

STEROIDS

Steroids such as prednisone greater than 20mg per day and methylprednisolone (Medrol) greater than 16mg per day can interfere with skin testing. Continue taking intranasal steroids (Flonase, Nasonex, QNASL, etc).

Patient History

Patient's Name (last, first, middle) _____ **Age** _____
Date of Birth ___/___/___ **Height:** _____ **Weight:** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Home (**)** _____ **Cell (** **)** _____ **Work phone (** **)** _____

PHYSICIAN INFORMATION

Were you referred by a physician? □ Yes □ No
If yes, please provide us with the name, address and phone number of the physician referring you:

Name of Physician Making Referral _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone Number (**)** _____ **Fax Number (** **)** _____
Would you like us to send a letter to your primary care physician regarding your visit with us? □ No □ Yes

Name of Primary Care Physician (If different than above) _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone Number (**)** _____ **Fax Number (** **)** _____

If there are other physicians whom you wish to receive copies of our evaluation, please list the names, address and phone numbers of these physicians below:

Other Physician 1 _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone Number (**)** _____ **Fax Number (** **)** _____

Other Physician 2 _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone Number (**)** _____ **Fax Number (** **)** _____

Other Physician 3 _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone Number (**)** _____ **Fax Number (** **)** _____

CHIEF COMPLAINT

Please describe, in your own words, the primary medical problem which has caused you to seek an evaluation.
Primary Medical Problem

_____
_____
_____

How long have you had this problem?

_____

Are your symptoms?
□ Continuous or □ Intermittent

ALLERGY SYMPTOMS Check all that apply.

1. Eyes □ Itching □ Watering □ Redness □ Sensitive to Light □ Swelling of Lids
   Is there discharge □ Yes □ No If yes, color of discharge
2. Ears □ Plugged □ Ache □ Discharge □ Infections
3. Nose □ Itching □ Congestion □ Runny □ Sneezing "Jags" □ Postnasal drainage
   □ Loss of Smell □ Sinus Infections □ Nasal polyp □ Loss of Taste
   □ Other (please describe)
4. Sore throat How often? Does this occur mostly in the a.m.? □ Yes □ No
5. Cough How often? Is your cough bothersome at night? □ Yes □ No
   Is sputum produced? □ Yes □ No If yes, what color
6. Headaches How often? What part of the head?
   Any other symptoms with the headache? □ Yes □ No If yes, describe
7. Sinuses Do you have sinus pain? □ Yes □ No
   Do you have loss of taste? □ Yes □ No
   Have you been treated with antibiotics for sinusitis? □ Yes □ No If yes, how often in the past year?
   Check each of the following treatments that you have used for your sinuses?
   □ Nasal Spray Decongestants □ Nasal Steroid Sprays
   □ Nasal Salt Water Irrigations □ Oral Decongestants □ Oral Antihistamines
   Have you ever had a sinus CT or X Rays? □ Yes □ No If yes, when?
   Have you ever undergone sinus surgery? □ Yes □ No If yes, complete the following:
   Name of Doctor _____ Name of Hospital/Facility _____

ASTHMA SYMPTOMS

1. Wheezing (Noisy breathing which may accompany asthma? When did it start? _____ How often? _____
   What makes it worse (colds, exercise, exposure to specific things?) _____
   Do you know what causes your wheezing? _____
   Is your wheezing getting: □ Better □ Same □ Worse
   List months when wheezing is worse
   What seasons do you wheeze? □ Winter □ Spring □ Summer □ Fall
2. Nocturnal Symptoms: Please check the respiratory problems (if any) which you have at night.
   □ Coughing which wakes you up □ Inability to sleep lying down flat due to cough or shortness of breath
   □ Significant sputum production during the night □ Awaken very congested and short of breath in the morning
   □ Wheezing or a feeling of chest tightness
3. Physical Performance

How far can you walk? (i.e., how many blocks) _____
How many flights of stairs can you climb without stopping? _____
What symptoms limit further activity? (e.g., cough, shortness of breath)
chest pain, fatigue, lightheadedness, leg cramps, weakness) _____
Do you have any of the following problems?
□ Excessive daytime sleepiness □ Loud snoring □ Restless sleep □ Difficulty concentrating during the daytime
□ More irritability than in the past □ Problems with sexual performance □ Headaches in the morning

4. Have you ever needed prednisone for your asthma? □ Yes □ No
   If so, how often?_____ How many times in the past year?_____
5. Have you ever been hospitalized for your asthma? □ Yes □ No
   If so, how often?_____ How many times in the past year?_____
   Have you ever been intubated after an asthma attack? □ Yes □ No When? _____
6. How often have you used albuterol during the day in the last month (daily, weekly)? _____
   How often have you used albuterol at night in the last month (daily, weekly)? _____

7. Trigger Factors: Please check each trigger factor that causes a worsening of your respiratory condition.

□ Exercise
□ Cold air
□ Wines, alcoholic beverages
□ House dusting/Vacuuming
□ Weather changes
□ Cigarette smoke
□ Occupational exposures
□ Perfumes or hairsprays
□ Air pollution
□ Aspirin and aspirin related drugs
□ Anti-statics for clothes
□ Damp, musty areas
□ Air conditioning
□ Tang or other yellow-colored foods
□ Others
□ Pollens (cut grass, wooded areas)
□ Sinus Infections
□ Menstrual cycles
□ Emotions or stress
□ Laughter
□ Bronchitis
□ Odors (please specify)
□ Cleansers, detergents, soaps
□ Colds, Flu
□ Car or truck exhaust
□ Animals (please specify)
□ Seasons of the year (please specify)
□ Foods (please specify)
□ Food additives (please specify)

SKIN HISTORY

1. Hives (urticaria) symptoms: When did it start/stop? _____ How often? _____.

   What portion of the body? _____ How long do individual hives last? _____

   When the hives first started, any new exposures (infections, soaps, pets, foods, stresses, insect stings)? _____

2. Swelling (angioedema): When did it start/stop? _____ How often? _____.

   What portion of the body? _____ How long does it last? _____

   Any family history? _____

3. Dermatitis (skin rash): When did it start/stop? _____ How often? _____.

   What portion of the body? _____ How long does it last? _____

4. Other skin findings _____ When did it start/stop? _____

   How often?_____ What portion of the body? _____

   How long does it last? _____

PAST ALLERGY HISTORY

Have you undergone skin testing? □ Yes □ No If yes, please provide the name of the physician and date(s) of these test(s):

DOCTOR'S NAME	DATE(S) OF TEST(S)

Have you received allergy shots? □ Yes □ No If yes, when did you receive them?_____ and for how long _____

Do you feel the allergy shot worked? □ Yes □ No If yes, please explain _____

Do you have any proven or suspected food allergies? □ Yes □ No If yes, complete below:

FOOD ALLERGEN	REACTION	FOOD ALLERGEN	REACTION	FOOD ALLERGEN	REACTION

Do you have any other allergy problems such as bee stings, allergies or eczema? □ Yes □ No If yes, complete below:

NON-FOOD ALLERGEN	REACTION	NON-FOOD ALLERGEN	REACTION	NON-FOOD ALLERGEN	REACTION

MEDICAL HISTORY

Please list current and past medical problems (e.g., diabetes, heart disease, cancer, etc).

PAST SURGICAL HISTORY

TYPE OF SURGERY	APPROXIMATE DATE	TYPE OF SURGERY	APPROXIMATE DATE

HOSPITALIZATIONS

Have you ever been hospitalized? □ Yes □ No If yes, complete below:

DIAGNOSIS OR REASON FOR HOSPITALIZATION	LENGTH OF HOSPITALIZATION	DATE OF ADMISSION

INFECTIONS

Do you have frequent infections (e.g., pneumonia, bronchitis, sinusitis, ear infections, etc)? □ Yes □ No If yes, complete below:

INFECTION SITE	APPROXIMATE DATE	INFECTION SITE	APPROXIMATE DATE

Did you have symptoms of asthma as a child? □ Yes □ No

Did you have frequent respiratory infections as a child? □ Yes □ No

Did you have exposure to passive cigarette smoke in infancy? □ Yes □ No

VACCINATIONS

DATE OF LAST FLU SHOT _____

DATE OF LAST PNEUMOCOCCAL VACCINE, IF RECEIVED _____

USE OF MEDICATIONS

Do you take inhaled bronchodilator medication such as Pro-Air, Albuterol, Ventolin, or Proventil? □ Yes □ No If yes, check how you take it below:

□ On a regular schedule, as prescribe by a physician? How often? _____

□ Intermittently, on an "as needed" basis? How often? _____

□ On a regular schedule, but with the addition of frequent inhaler treatments "in between" the schedule doses? How often? _____

When was your last dose of an inhaled bronchodilator? _____

Have you taken oral steroids (Prednisone or Medrol) in the past? □ Yes □ No If yes, how many times in the last year? _____

Pharmacy Name _____

Pharmacy Number _____ Pharmacy Fax Number _____

ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS

Please list the names of any medications to which you have experienced an allergic or adverse reaction.

MEDICINE	REACTION	MEDICINE	REACTION

FAMILY HISTORY

List immediate family (parents, brothers, sisters and children) having any of the following illnesses:

CONDITION/DISORDER		FAMILY MEMBER(S)	CONDITION/DISORDER		FAMILY MEMBER(S)
Allergic Rhinitis (hayfever)	□ Yes □ No		Angioedema/ Swelling	□ Yes □ No	
Asthma	□ Yes □ No		Cystic Fibrosis	□ Yes □ No	
Cancer	□ Yes □ No		Emphysema	□ Yes □ No	

List any other diseases that run in your family:

CONDITION/DISORDER	FAMILY MEMBER(S)	CONDITION/DISORDER	FAMILY MEMBER(S)

SOCIAL & OCCUPATIONAL HISTORY

Marital Status □ Married □ Single □ Widowed □ Divorced □ Separated List number of children _____ Ages _____
Do any of your children have any chronic illnesses? □ Yes □ No If yes, explain _____
Do you drink alcohol? □ Yes □ No If yes, how much _____ per week Drink of choice_____ □ Quit
Do you use street drugs? □ Yes □ No If yes, list kind and amount _____ □ Quit
Do you use tobacco? □ Yes □ No (if yes, answer "Present Use" below) □ Quit (if quit, answer "Past Use" below)

PRESENT USE

□ Cigarettes_____per day Age started_____for____years
□ Cigars_____per day Age started_____for____years
□ Pipe_____per day Age started_____for____years
□ Smokeless_____per day Age started_____for____years

PAST USE

□ Cigarettes___per day Age started____for_____years
□ Cigars_____per day Age started____for_____years
□ Pipe_____per day Age started____for_____years
□ Smokeless___per day Age started_____for____years

Are you currently employed? □ Yes □ No What is your current occupation? _____
If yes, how many hours per week do you work? _____
Do you believe that your current or previous occupation has any bearing on your illness? □ Yes □ No If yes, please explain?
_____

How much work or school have you missed due to your breathing difficulty within the past year? _____
Please describe the effect of your illness on your job or school performance _____
Do you anticipate that your evaluation will be used in any legal action against your current or former employer? □ Yes □ No
Have you ever worked in a factory, textile mill, farming, grain mill, and shipyard or in a mine? □ Yes □ No If yes, please explain:
_____

Have you had any job with high exposure to fumes, chemicals, dust or other noxious substances? □ Yes □ No If yes, please explain:
_____

What kind(s) of exercise do you perform regularly? _____ How often? _____
What, if any, hobbies or leisure activities do you engage in? _____

ENVIRONMENTAL HISTORY

Please describe your current living situation (private home, apartment, living with relatives) _____

Where is the living area located (i.e. rural city, near any major factories or industries, etc)? _____

Age of living area _____ How long have you lived there? _____ How many people live there? _____

HOME DESCRIPTION		FURTHER DESCRIPTION, IF NECESSARY
Basement	□ Yes □ No	
Any water damage in basement?	□ Yes □ No	
Smokers in the home?	□ Yes □ No	
Air conditioning?	□ Yes □ No	□ In window(s) □ Central Air
Forced/central air heating?	□ Yes □ No	□ Gas □ Electric
Fireplace?	□ Yes □ No	Used how often?
Wood burning stove?	□ Yes □ No	Used how often?
Do you vacuum the home?	□ Yes □ No	
Air purification systems?	□ Yes □ No	
Pillow and mattress dust-proof covers?	□ Yes □ No	
Do you use a humidifier?	□ Yes □ No	
Pets?	□ Yes □ No	What kind? How many?
		Where do your pets sleep?
Fabric softener used?	□ Yes □ No	
Fragrances used?	□ Yes □ No	What kind?
- cologne, perfume, candles, air freshener		
Plants in the home?	□ Yes □ No	How many? Where kept?
Is there carpeting in your bedroom?	□ Yes □ No	
Do you have wall-to-wall carpeting?	□ Yes □ No	Age of carpeting?
What is the age of your mattress?		
What is the age of your pillows?		
What type of pillows?	□ Synthetic (polyester, fiber, foam) □ Feather □ Other	

REVIEW OF SYSTEMS

Please check any of the following symptoms which you are currently experiencing, or which have caused you serious problems in the past.

Constitutional	□ fever	□ weight loss	□ weight gain
	□ night sweats	□ severe itching	□ loss of appetite
	□ fatigue	□ cold intolerance	□ heat intolerance
Special senses	□ loss of vision	□ blurry vision	□ cataracts
	□ glaucoma	□ loss of hearing	□ itching in ears
	□ ringing in ears	□ loss of balance	□ loss of sense of smell
	□ dry eyes	□ excessive tearing	□ loss of sense of taste
	□ itchy eyes	□ conjunctivitis	□ ear infections
Lymph glands	□ glandular swelling	□ glandular tenderness	
Heart	□ chest pain	□ palpitations	□ swelling of ankles
	□ inability to lie flat in bed		
Intestinal tract	□ nausea	□ vomiting	□ heartburn
	□ indigestion	□ abdominal pain	□ constipation
	□ diarrhea	□ excessive gas	□ gall stones
	□ food intolerance	□ acid or sour taste in mouth	□ trouble swallowing liquids or foods
Reproductive	□ irregular periods	□ skipped periods	□ unusual vaginal bleeding
	□ menopause	□ infertility	□ miscarriages
	□ impotence	Are you pregnant or planning a future pregnancy? □ Yes □ No	
Urinary	□ kidney stones	□ inability to urinate	□ prostate problems
	□ kidney infections		
Rheumatologic	□ joint swelling	□ joint pain	□ low back pain
& Orthopedic	□ fractured bones	□ early morning stiffness	□ gout □ osteoporosis
Skin	□ skin rash	□ hives	□ eczema
	□ excessive hair loss	□ skin tumors or growths	
Neurological	□ passing out spells	□ severe headaches	□ epilepsy seizures
	□ difficulty with memory	□ inability to concentrate	

Please describe any symptoms which are particularly bothersome for you _____

_____

_____

_____

_____

Name _____

DOB _____

Medication Record

Please list all medications you are currently taking. Include medicines prescribed by your doctor, over-the-counter medicines (examples: allergy relief; antacids; cold/cough medicines; laxatives; aspirin; Tylenol© or other pain medicines; diet pills; etc.) herbal products (e.g., gingko biloba, St. John's Wort, ginseng, green tea, etc.), vitamins and nutritional supplements (examples; multi-vitamins, calcium, fish oil, glucosamine, chondroitin, Glucerna©, etc)

Name of Local Pharmacy _____ **Name of Mail Order Pharmacy** _____

City _____ **City** _____

Phone ( ) _____ **Fax ( )** _____ **Phone ( )** _____ **Fax ( )** _____

INSURANCE INFORMATION

Insurance Company _____ **Name of Subscriber** _____

ID Number _____ **Group Number** _____ **Relationship Code** _____

★Bring all your medicine bottles with you to your appointment★

Medication Name	Dose (How much)	Frequency (How Often)

DRUG ALLERGIES: Please list any medications you have had a reaction to

Name of Medicine	Reaction	Name of Medicine	Reaction	Name of Medicine	Reaction

Patient's Signature _____ **Date** _____

Physician's Signature _____ **Date** _____