Coastal Carolina Otolaryngology

COA

Allergy Questionnaire

Name: _____ DOB:_____ Date: _____

1. Have you been allergy tested before? ☐ Yes ☐ No

If yes: When?_____ Where? _____

2. Please choose all of the symptoms that you experience:

☐ Wheezing	☐ Hearing loss	☐ Snoring
☐ Sneezing	☐ Shortness of breath	☐ Fatigue
☐ Congestion	☐ Loss of smell	☐ Runny nose
☐ Postnasal drainage	☐ Bad breath	☐ Eczema
☐ Loss of voice	☐ Headaches	☐ Frequent clearing of throat

3. Are your symptoms seasonal or year-round? _____

4. Do your symptoms flare up often? ☐ Yes ☐ No

How long do your flare-ups last? _____

5. Are your symptoms worse during a certain time of day?_____

6. Are your symptoms worse during certain seasons? _____

7. Do you have upper respiratory infections more than three times a year? ☐ Yes ☐ No

8. Do you have pets? ☐ Yes ☐ No

If so, what kind?_____

9. How long have you lived in the area? _____

10. How long have you lived at your current address? _____

11. Did you have allergy or asthma symptoms in your previous residence or state? ☐ Yes ☐ No

12. Do you have a family history of asthma? ☐ Yes ☐ No

13. Were you diagnosed with asthma as a child? ☐ Yes ☐ No

14. Please choose all the medications below that you have taken in the last year:

☐ Inhalers	☐ Cough syrups/drops	☐ Antidepressants
☐ Antihistamines	☐ Nose sprays	☐ Sleep medications
☐ Eye drops	☐ Beta-blockers	☐ Antacids
☐ Decongestants	☐ Blood thinners	

15. Have you had or do any of the following apply to you?

☐ Asthma	☐ Food allergy	☐ Hives
☐ Anaphylaxis	☐ Angioedema	☐ Dermatographism
☐ Beta-blockers	☐ Pregnancy	

Coastal Carolina Otolaryngology

Allergy Testing Patient Instructions

Your appointment is on: _____

Your doctor or provider has recommended that you be tested for allergies to determine if various pollens or other airborne allergens may be contributing to your current symptoms.

You must stop certain medications prior to allergy skin testing.

Please **DO NOT** take any medications that contain antihistamines for 5-7 days prior to the testing. These include, but are not limited, to the following:

- Common antihistamines (This is not a complete list)
- Benadryl (diphenhydramine), Claritin (loratadine), Allegra (fexofenadine), Zyrtec (cetirizine), Xyzal (levocetirizine), Clarinex (desloratadine)
- Over-the-counter cold and cough remedies
- Dimetapp, Robitussin, Tylenol Cold and Sinus, Chlor-Trimeton
- Prescription or over-the-counter sleep aids
- Ambien, Lunesta, Midol PM, Tylenol PM, Excedrin PM, Dramamine
- Nasal spray antihistamines
- Patanase, Astepro, Astelin
- Eye drop antihistamines
- Optivar, Pataday
- Herbal supplements, multivitamins and vitamin C
- Must be stopped seven days prior to testing

Please wear a **SHORT-SLEEVE SHIRT**, as the allergy testing will take place on the upper and lower arms. The testing will take between 60 to 90 minutes to complete. ***PLEASE MAKE SURE YOU ARE ON TIME.***

If you are on a beta-blocker, we cannot perform testing unless a prescribing M.D. will give you another form of medication.

Examples of beta-blockers are:

- Bystolic (nebivolol)
- Coreg (carvedilol)
- Corgard (nadolol)
- Inderal (propranolol)
- Levatol
- Lopressor (metoprolol)
- Tenormin (atenolol)
- Zebeta (bisoprolol)
- Timolol (eye drops for glaucoma)