

THE DEPARTMENT OF ALLERGY, ASTHMA & IMMUNOLOGY

1635 Divisadero Street Suite 101
San Francisco, CA 94118
(415) 833-3780, press 3

Appointment Date: _____

Your INTAKE appointment time is at: _____, which includes vitals and a breathing test.

You will see Dr. _____ **after your intake appointment.**

Dear Allergy Patient,

Welcome to the Department of Allergy, Asthma & Immunology at Kaiser Permanente Medical Center in San Francisco.

Prior to your arrival in the Allergy Department, it is important that you fill out and bring with you the enclosed **questionnaire**. Upon your first visit, the doctors will have already reviewed your medical history. The enclosed questionnaire will allow your physician to be even more familiar with your allergy/asthma history.

- ❖ **If skin testing is ordered** and you wish to receive the tests on the day of your visit, please withhold all antihistamines for **4** days. This does **NOT** apply for those seeking treatment for **hives**.
 - Certain time constraints may not allow us to perform testing on that day.
If your symptoms are too severe to withhold antihistamines, please don't stop your antihistamines.

- ❖ **In addition, you will have a pulmonary function test.**
 - If possible, please withhold albuterol (ventolin) inhaler or other relief inhalers for at least 6 hours prior to this test.
If your symptoms are too severe, please don't stop your albuterol.
 - If you are on Serevent®, Advair®, Symbicort®, or Foradil®, please withhold for 24 hours prior to your appointment.
If your symptoms are too severe, please don't stop your albuterol or withhold your medication.
 - Please continue to take all other inhaled medications.
 - Be sure to eat a light meal prior to your testing appointment.

Please register 15 minutes before your appointment time. This will allow us time to determine your height, weight and blood pressure and process your records before you see the physician.

If the patient is under 18 years of age, a parent or guardian must be present.

If you have any questions about your upcoming visit, or need to change your scheduled appointment, please do not hesitate to call our staff at (415) 833-3780 and press 3. We hope your experience is beneficial and we look forward to your visit.

Sincerely,

Faith R. Bocobo, M.D.
Calvin So, M.D.
Peg Strub, M.D, Chief
Jodi Thirtyacre, Manager

ALLERGY, ASTHMA & IMMUNOLOGY QUESTIONNAIRE
Please complete and check all that apply

Name: _____ MR#: _____ Age _____ Date _____

Home phone: _____ Work phone: _____ Cell phone: _____

Occupation: _____

1. Who referred you to the Allergy Department? _____
2. Which **allergy** related symptoms bother you the most? _____
3. How long have you lived in the Bay Area? _____ at your present address? _____

CURRENT SYMPTOMS AND COMPLAINTS – PLEASE CHECK (✓) ALL THAT APPLY

CHEST	NOSE	EARS	EYES	THROAT	SKIN
<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Wheeze <input type="checkbox"/> Tightness <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Itching <input type="checkbox"/> Congestion <input type="checkbox"/> Sneezing <input type="checkbox"/> Running	<input type="checkbox"/> Itching <input type="checkbox"/> Blockage	<input type="checkbox"/> Itching <input type="checkbox"/> Tearing	<input type="checkbox"/> Itch/Tickle <input type="checkbox"/> Hoarseness <input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> Dry Skin <input type="checkbox"/> Hives <input type="checkbox"/> Rash

-Are you worse with Dust/Dust mite Animals Mold/Mildew Pollen Exercise
 Respiratory Infections Smoke/Fireplace Indoors Outdoors Other

-Are you better with Indoors Outdoors Vacations Exercise Medications

4. When did your symptoms begin? _____
5. When are your symptoms present? Year-long Seasonal Other _____
6. Severity of your symptoms on a scale of 0 -10? (**0 is normal, 10 is very severe**) _____
7. How many days have you missed from work/school because of your symptoms in the past year? _____

OTHER ALLERGY PROBLEMS

- 1) Please describe any **medication allergies** _____
- 2) Please describe any **food allergies** _____
- 2) Have you had a reaction to mango, apple, chestnut, kiwi, avocado, hazelnut, banana, melon, papaya? No Yes
- 4) Have you had a reaction with rubber/latex i.e. pacifier, gloves, balloons, condoms, diaphragm? No Yes
- 5) Do you or your co-workers wear latex/rubber gloves or are you exposed to latex in any way? No Yes
- 6) Have you had a **severe** reaction to a bee, wasp, or hornet sting? No Yes

ASTHMA PLEASE COMPLETE ONLY IF YOU HAVE ASTHMA

How would you rate your asthma on a scale of 0 -10? (0 is normal, 10 is very severe) _____

Do you have? Peak Flow Meter Asthma Self-Management Plan Spacer Device

How many times have you: total # times # in past 12 months

- | | | |
|---|-------|-------|
| - gone to the Emergency Room or Urgent Care for asthma? | _____ | _____ |
| - taken prednisone / cortisone "burst" for asthma? | _____ | _____ |
| - had a hospitalization for asthma? | _____ | _____ |
| - been admitted to the ICU for asthma? | _____ | _____ |

FAMILY HISTORY: List relatives with nasal allergies, asthma, food allergy, eczema OR other allergic disease

PAST MEDICAL HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> Glaucoma, Cataracts | <input type="checkbox"/> Liver Disease, Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Mental Health Disorder |
| <input type="checkbox"/> Lung Problem | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Menopause | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Has anyone ever said you stopped breathing while sleeping? |
| <input type="checkbox"/> Heartburn/ Hiatal Hernia | <input type="checkbox"/> Neurological Problem | |

Hospital/surgery/Emergency Department visits

SOCIAL HISTORY

- 1) Marital Status: Single Married Divorced Widow Partnered Separated Other _____
- 2) Please list your hobbies: _____
- 3) Spouse/Partner's Occupation - *if applicable*: _____
- 4) Smoking history: Currently Previously smoked: Date quit _____ Years smoked _____
How many per day: Cigarettes _____ (Packs) Cigars _____ Pipes _____
 Live with smoker Never smoked
If you still smoke, are you interested in quitting in the next 6 months? No Yes
- 5) Do you drink alcohol? Never Former Regular Occasional Rarely
 Red/White Wine Beer Other _____ **Amount per day or per week** _____
- 6) Do you use recreational drugs? Yes No Please specify _____
- 7) Please specify if you or anyone else ever been concerned about your alcohol/drug use _____

WORK/SCHOOL - Please list most recent employer / school.

- 1) Job Title _____ Years performed/attended _____
- 2) Where do you work or attend school? _____
- 3) Describe your work or major field of study? _____
- 4) If work/school affects your allergies, please describe _____

ENVIRONMENTAL EXPOSURE

AREA/DURATION -List the places you have lived for more than 2 years.

1) Living Quarters: ___ Apartment ___ Flat ___ House ___ Condominium ___ In-law Apartment ___ Other _____

Pillow	Blanket	Mattress	Flooring	Windows	Animals
___ Synthetic	___ Down	___ On Frame	___ Wall-to-Wall	___ Blinds	___ Cat # _____
___ Feather	___ Wool	___ Standard Mattress	___ Carpeting	___ Shades	___ Dog # _____
___ Foam/Rubber	___ Synthetic	___ Box Spring	___ Area Rug	___ Curtains	___ _____ # _____
	___ Cotton	___ Water Bed	___ No Carpeting	___ Drapes	
	___ _____	___ Futon	___ _____	___ _____	
		___ Foam rubber			
		___ _____			

Other	Heating
___ Roof Leak	___ Central Heat
___ Roaches	___ Wall/Space Heater
___ Mold	___ Fireplace in BR
___ Stuffed Animals	___ Bedroom Vent
___ Open Bookcases	___ _____
___ Clutter	
___ Plants	
___ _____	

CURRENT MEDICATIONS: Please list all medications including topical, vitamins and herbal supplements

REVIEW OF SYSTEMS

___ Unexpected weight loss	___ Leg swelling	___ Loss of consciousness
___ Blurred Vision	___ Vomiting	___ Hallucinations
___ Nosebleeds	___ Change in urinary habits	___ Bleeding problems
___ Coughing up blood	___ Falls	___ Excessive thirst



Department of Allergy, Asthma & Immunology

SKIN TESTING INFORMATION

WHAT HAPPENS DURING SKIN TESTING?

You will be tested on your lower and upper arms. Twenty minutes after each test a nurse will check the reaction.

Lower arm testing is done with a disposable puncture device.

Upper arm testing is done with a tin disposable needle just under the skin.

HOW DO I PREPARE FOR SKIN TESTING?

1. **GENERAL INFORMATION:** Testing is generally well tolerated and does not require special preparation in advance. Please tell the tester or nurse if you're not feeling well before your tests.

Eat a normal meal **before** testing. Do not plan vigorous activity **following** testing.

Please allow enough time in your schedule in case extra time is necessary for observation.

2. **MEDICATIONS:** Please do not take any antihistamines for 4 days before testing, as directed by your physician. If you're taking medicine for your heart, blood pressure, depression, or eye drops please check with the nurse. Almost all other medications can be taken as usual.
3. **CLOTHING:** Wear clothing with loose-fitting sleeves, so you can expose your upper and lower arms. If at all possible, please wear short sleeves.

HOW LONG DOES SKIN TESTING TAKE?

Each visit will take about 1½ hours. Since you must be observed during the time, you will not be able to leave the waiting room. Therefore, it is important that you use the restroom or telephone **before** you begin testing. After you finish testing, you will need to set up an appointment to see the doctor to go over your test results. Depending on your situation, the doctor may order different kinds of tests.

HOW WILL SKIN TESTS MAKE ME FEEL?

Most people feel fine after the tests. Testing can sometimes cause adverse effects. A positive test will routinely result in a round, itchy welt surrounding redness. It is possible that the tests may leave marks on your arms. These marks rarely persist, depending on your skin type.

Occasionally patients develop generalized allergic symptoms that need immediate attention. Very rarely these allergic reactions can be serious and life threatening. Please tell us promptly if you develop itching, wheezing, difficulty breathing, or swelling.

PATIENTS UNDER 18: Must have an adult present.