



Allergy Department Skin Testing Information

Skin Testing is done to identify the substances/allergens that trigger your allergy symptoms when you are exposed to them.

WHAT HAPPENS DURING SKIN TESTING?

You will be tested on your arms or back. Twenty minutes after each test, a nurse will check the reaction. Arm or back testing is done with a disposable puncture device. Upper arm testing is done with a thin 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 are 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 before testing, various antihistamines have to be discontinued at different times as instructed by your doctor. If you are 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, including your inhalers for asthma.

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 kind 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.

Your doctor and/or nurse will discuss this with you before proceeding with the testing.

ALLERGY AND IMMUNOLOGY QUESTIONNAIRE

PATIENT NAME	DATE
OCCUPATION	AGE

IMPRINT AREA

Please check your symptoms and complaints:

CHEST	NOSE	EARS	EYES	THROAT	SKIN	OTHER
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Itching	<input type="checkbox"/> Itching	<input type="checkbox"/> Itching	<input type="checkbox"/> Itching	<input type="checkbox"/> Headache
<input type="checkbox"/> Cough	<input type="checkbox"/> Congestion	<input type="checkbox"/> Blockage	<input type="checkbox"/> Tearing	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Hives	<input type="checkbox"/> _____
<input type="checkbox"/> Wheeze	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Frequent infection	<input type="checkbox"/> Swelling	<input type="checkbox"/> Frequent infection	<input type="checkbox"/> Eczema	<input type="checkbox"/> _____
<input type="checkbox"/> Tightness	<input type="checkbox"/> Running		<input type="checkbox"/> Redness	<input type="checkbox"/> Post nasal drip		<input type="checkbox"/> _____
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Itching			<input type="checkbox"/> Soreness		<input type="checkbox"/> _____
<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Polyps			<input type="checkbox"/> Dryness		
<input type="checkbox"/> Congestion	<input type="checkbox"/> Loss of smell			<input type="checkbox"/> Bad Breath		
	<input type="checkbox"/> Discharge					

Which symptoms cause you the most concern? _____

When did your symptoms begin? _____ Month _____ Year _____

In what city or area were you when you first experienced your symptoms? _____

Are your symptoms worse any season of the year? If so, which months; _____

Worst month(s)? _____ Best month(s)? _____

Frequency of attacks? Daily Weekly Monthly Worse: Day Evening Night

FAMILY HISTORY:

	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Nasal Allergies (Hay Fever)						
Asthma						
Sinusitis						
Hives						

List all known allergies to drugs and food: (if none, please write none).

<u>Name of Drug</u>	<u>Describe Reaction</u>
A. _____	_____
B. _____	_____
C. _____	_____
D. _____	_____

Medicines: Include birth control pills, vitamins, and aspirin products if used often. Give the strength of prescription drugs you presently take.

A. _____	D. _____
B. _____	E. _____
C. _____	F. _____

Hospitalizations and operations:

<u>YEAR</u>	<u>Reason for Hospitalization</u>
A. _____	_____
B. _____	_____
C. _____	_____
D. _____	_____
E. _____	_____

Have you had previous skin testing? No Yes, when? _____

If your symptoms include hay fever, nasal allergy, "sinus", wheezing, cough, shortness of breath, or asthma, please read the following list. Carefully and indicate by placing an "X" in the appropriate boxes to the left of those items that cause or aggravate, relieve or have no apparent effect upon your allergy symptoms. EVEN A SMALL CHANGE IS SIGNIFICANT. If you have never encountered the situation or item, please leave all three boxes blank. If your symptoms DO NOT include any of those mentioned above, please leave this section blank.

Causes or Aggravates	Relieves	No Effect	Items
			Lawn mowing, grass contact
			Weed contact, <i>specify</i> :
			Blossoming trees, <i>specify</i> :
			High winds, riding in auto with open windows
			Strong odors, sprays, perfumes, paints
			Musty, moldy, or mildewed places or articles
			Going indoors
			Going outdoors
			Sweeping, dusting, vacuuming in the house, dusty books, etc.
			Any animals, <i>specify</i> :
			Aspirin or aspirin-containing medications
			Emotional upset
			Exertion or strenuous exercise, <i>specify</i> :
			Respiratory infections, virus infection, "flu"
			Air conditioning, swamp coolers, etc., please circle
			Antihistamines or nasal decongestants (Contac, Dristan, Allerest, Dimetapp, Ornade, Drixoral nasal spray, etc.), <i>specify</i> :
			Medications for wheezing (Tedral, Marax Bronkaid, theophylline, aminophylline, terbutaline, Alupent, etc.), circle and <i>specify</i> if other:
			Corticosteroids (cortisone type drugs), <i>specify</i> :
			Other drugs which aggravate or relieve symptoms, <i>specify</i> :
			Very cold weather, changes in temperature or barometric pressure, <i>please circle</i>
			Any trips out of this area, <i>specify</i> place and time of the year:
			Alcoholic beverages, <i>specify</i> :
			Menstrual periods and/or pregnancy, <i>please circle</i>
			Tobacco smoke and other smokes, smog, fumes and haze, <i>please circle</i>
			Anything else you have noticed that changes your symptoms, <i>specify</i> :

1. Smoking in house **Yes** **No**
 Patient smokes
 _____ packs _____ years

4. Are you sensitive to latex **Yes** **No**
 i.e. rubber gloves, condoms?

2. Alcohol _____ daily _____ social

3. Nonprescription drugs

ENVIRONMENT: Please check:

House = own rent _____ years

Apartment = own rent _____ years

Animals = indoor outdoor bedroom

Pillow = leather foam synthetic

Carpet = wall to wall wood floor

Heating = wall heater central heat gravity

Mattress = standard waterbed

Box Spring = standard none

Mold = indoor plants bathroom kitchen basement walls