

INSTRUCTIONS FOR ALLERGY TESTING

****If you are taking a beta blocker – a class of cardiac drugs – you may NOT be allergy tested****

****Do not discontinue this drug on your own.****

I _____, am not currently taking a beta blocker and I will call the office if I am prescribed one before my allergy testing appointment.

Some medications, called antihistamines, inhibit the allergic reaction and should not be taken for 1 week before allergy test is performed, or a false negative result will occur. Most of these are allergy medications, over-the-counter sleep aids, or cold/flu medications. **A list of common medications that interfere with allergy skin testing is included on the second page.** _____

If you are taking medication with antihistamine which cannot be stopped because of the severity of your condition, continue taking the medication and let us know right away. If you have major hives or swelling, do not stop your antihistamines and contact our office.

Do not stop asthma medications or any other medications that do not contain antihistamines, such as antibiotics, Nasonex, Flonase, Veramyst, other steroid-only nasal sprays, plain Sudafed, Afrin, NeoSynephrine, Singulair, prednisone/medrol dose pack, Lotemax eye drops, Rhinocort, Nasocort, Mucinex, all asthma inhalers, dextromethorphan cough medications (like Delsym), or Prevacid.

If you have any questions about the possible effect of other medications you might be taking, do not hesitate to contact us 703-573-3687.

- If you have a cold, fever, or have an asthma/hay fever attack, testing should be delayed. _____
- Do not change your diet before the test. _____
- Do not use oil, cream, or lotion on your arms for 24 hours prior to skin testing. _____
- Make sure you eat breakfast/lunch before coming to your appointment. _____
- Please wear sleeveless or short-sleeved apparel for testing. _____
- If you have long hair, please bring a hair tie to tie back hair during testing. _____
- Remember to bring this completed questionnaire with you for your appointment. _____

If you cannot keep your appointment or follow the above instructions for any reason, please notify our office at least 2 days in advance or you will be charged \$150.00 for a missed appointment

****If any unusual symptom, such as sneezing, coughing, itching, hives, or asthma occurs AFTER the allergy testing, please contact our office (703) 573-3687****

Patient Signature: _____

Do not take the following for at least 1 week before your allergy testing appointment (if you cannot stop these medications, please notify our office (703) 573-3687:

Common Medications Containing Antihistamines:

Actifed (Chlorpheniramine)	Meclizine (Antivert, Bonine)
Advil PM (Diphenhydramine)	Mirtazapine (Remeron, Soltab)
Advil Allergy (Chlorpheniramine)	Nizatidine (Axid, Tazac)
Alavert (Loratadine)	Normramine (Deipramine)
Allegra (Fexofenadine)	Nortriptyline (Pamelor)
Alka Seltzer PM (Diphenhydramine)	Nyquil (Doxylamine)
Amitriptyline (Elavil)	Nytol (Diphenhydramine)
Antivert (Meclizine)	Olopatadine (Patanase Nasal Spray)
Astelin Nasal Spray (Azelastine)	Pamelor (Nortriptyline)
Astemizole (Hismanal)	Patanase Nasal Spray (Olopatadine)
Astepro Nasal Spray (Azelastine)	PBZ (Pyribenzamine)
Atarax (Hydroxyzine)	Pediacare Multi-Symptom Cold (Chlorpheniramine)
Azelastine Nasal Spray (Astelin, Astepro)	Periactin (Cyproheptadine)
Benadryl (Diphenhydramine)	Phenergan (Promethazine)
Bonine (Meclizine)	Pheniramine (Avil)
Brompheniramine (BroveX, Dimetapp, Dimetane)	Promethazine (Phenergan)
BroveX (Brompheniramine)	Protriptyline (Vivactil)
Cetirizine (Zyrtec)	Pyribenzamine (PBZ)
Chlorcyclizine (Dallergy)	Pyrilamine (Midol)
Chlorpheniramine (Chlor-Trimeton, Actifed, Tussionex, Contac, Coricidin)	Ranitidine (Zantac)
Chlor-Trimeton (Chlorpheniramine)	Remeron (Mirtazapine)
Clarinox (Desloratadine)	Robitussin Allergy (Brompheniramine)
Claritin (Loratadine)	Rondec (Chlorpheniramine)
Clemastine (Tavist)	Rynatan (Chlorpheniramine)
Congentin	Sinequan (Dozepam)
Contac Cold and Flu Night (Chlorpheniramine)	Sominex (Diphenhydramine)
Coricidin (Chlorpheniramine)	Sudafed Nighttime Cold/Plus (Diphenhydramine)
Cyproheptadine (Periactin)	Surmontil (Trimipramine)
Dallergy (Chlorcyclizine)	Tavist (Clemastine)
Desipramine (Norpramine)	Theraflu (Chlorpheniramine)
Desloratadine (Clarinox)	Tofranil (Imipramine)
Dexbrompheniramine Maleate (Drixoral)	Tylenol PM (Diphenhydramine)
Dimenhydrinate (Dramamine)	Tussionex (Chlorpheniramine)
Diphenhydramine (Benadryl)	Unisom (Doxylamine)
Dimetane (Brompheniramine)	Vistaril (Hydroxyzine)
Dimetapp (Brompheniramine)	Vivactil (Protriptyline)
Doxepin (Sinequan, Adapin)	Zytrec (Cetirizine)
Doxylamine (NyQuil)	Xyzal (Levocetirizine)
Dramamine (Dimenhydrinate)	
Drixoral (Dexbrompheniramine Maleate)	
Duravent LA (Chlorpheniramine)	
Dymista (Azelastine Hydrochloride)	
Elavil (Amitriptyline)	
Excedrin PM (Diphenhydramine citrate)	
Famotidine (Pepcid)	
Fexofenadine (Allegra)	
Hismanal (Astemizole)	
Hydroxyzine (Atarax, Vistaril)	
Imipramine (Tofranil)	
Levocetirizine (Xyzal)	
Lodrane (Brompheniramine maleate)	
Loratadine (Claritin)	

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PATIENT: _____ DOB: _____ TODAY'S DATE _____

Carefully complete in FULL. Accuracy and thoroughness are essential. Please circle all multiple choice answers and fill in the blanks where applicable.

IS YOUR PRESENT HOME: a. an apartment in a high rise?
 b. a single family house?
 c. a small apartment house?

HOW LONG HAVE YOU LIVED AT THIS RESIDENCE? _____

HOW OLD IS THIS HOUSE? _____

IS THIS HOUSE LOCATED IN: a. a rural area?
 b. a heavily wooded area?
 c. an industrial area?

TYPE OF HEATING: a. forced air d. space heater
 b. hot water e. floor furnace
 c. steam

FILTERS: a. conventional furnace filter b. electrostatic filter system

HUMIDIFIERS: a. central humidifiers b. room humidifiers

AIR CONDITIONING: a. central air b. room air conditioning

IS THIS HOUSE BUILT ON: a. a cement slab
 b. over a basement
 c. over a crawl space

IF YOU HAVE A BASEMENT, IS IT: a. dry b. damp

DO YOU SEE MOLD OR MILDEW IN YOUR HOUSE? yes no if so, where? _____

DOES YOUR HOUSE or BASEMENT SMELL MUSTY? house basement both

HOW MANY HOUSEPLANTS DO YOU HAVE INSIDE YOUR HOME? _____

BEDROOM:

YOUR BEDROOM IS ON: a. first floor c. basement
 b. second floor d. other floor _____

HOW MANY BEDS ARE THERE IN YOUR BEDROOM? _____

MATTRESS: a. cotton felt b. innerspring c. foam rubber

HOW OLD IS YOUR MATTRESS? _____

Patient's Name: _____

IS YOUR MATTRESS ENCLOSED IN PLASTIC? _____

SPRINGS: a. box springs b. open coil springs c. bunk bed

MATTRESS PAD: a. Dacron b. cotton c. none

PILLOWS: a. feathers c. Kapok e. Dacron
b. cotton d. foam rubberBED COVERS: a. Chennile spread c. Dacron spread e. Dacron comforter or quilt
b. cotton spread d. cotton comforter or quilt

DO YOU TAKE A SHOWER OR A BATH BEFORE YOU RETIRE AT NIGHT? _____

DO YOU HAVE ANY OF THE FOLLOWING IN YOUR BEDROOM?

- | | |
|--------------------------|--------------------|
| a. upholstered furniture | d. model cars |
| b. library | e. model airplanes |
| c. stuffed toys | f. Venetian blinds |

LIVING AND FAMILY ROOM:FURNITURE STUFFED WITH: a. cotton d. Dacron
b. feather or down e. foam rubber
c. Kapok f. other _____THROW PILLOWS STUFFED WITH: a. cotton d. Dacron
b. feather or down e. foam rubber
c. Kapok f. other _____

CURTAINS AND DRAPES ARE MADE OF WHAT MATERIAL? (cotton, fiberglass, etc.) IN:

Bedroom: _____	Living room: _____
Dining room: _____	Family room: _____

TYPE OF RUG? (wool, synthetic, etc.) IN:

Bedroom: _____	Living room: _____
Dining room: _____	Family room: _____

TYPE OF RUG PAD: (Ozite, hair, foam rubber, etc) IN:

Bedroom: _____	Living room: _____
Dining room: _____	Family room: _____

PETS: a. dog c. bird e. rabbit g. gerbils i. other _____
b. cat d. hamster f. mice h. guinea pig

If any of the above are circled, please indicate how many of each animal and for how long each has been present in your household _____

Please list all present and recent past medications. (Include nose drops, aspirin, diet pills, birth control pills, etc.)

Patient's Name: _____

Have you had generalized itching, hives, weakness, sweating, shortness of breath or wheezing after an insect bite or sting? _____

Have you had any of the above symptoms after eating or drinking any food or beverage? _____

Have you had any of the above symptoms after taking medications? _____

Do you, or have you, smoked in the past 10 years? _____

How much? _____

Are you interested in quitting smoking? _____

Would you consider taking medication to help you quit smoking? _____

IS THERE A HISTORY OF ASTHMA, HAYFEVER, HIVES or ECZEMA IN YOUR:

- a. mother
- b. father

- c. siblings - how many? _____
- d. children - how many? _____

HOW LONG DO YOU EXPECT TO LIVE in the NORTHERN VIRGINIA/D.C. AREA?
