# Welcome to the Platte Valley Allergy and Asthma Clinic

## Getting Ready for Your Visit

Thank you for choosing Platte Valley Medical Clinic for your allergy and asthma care.

#### What should I expect at the clinic?

At your first visit, we'll ask about your medical history, symptoms and allergy and asthma triggers. We'll do an exam and talk about tests we might want to do to learn the cause of your symptoms. Then we'll find the treatment that best meets your needs.

### What is allergy skin testing?

Your doctor may order skin tests to find out what triggers your symptoms. If so, your total visit will take about 90 minutes. The skin tests takes about 15 to 20 minutes.

Skin testing involves one or more gentle pricks on the skin. If you are allergic to a substance, the skin around the test area will turn red.

Your doctor will review your results after the tests.

#### How should I get ready for this visit?

#### Bring medicines and allergy records

Please bring these to your visit:

- All medicines that you take
- Records of any allergy care you've had in the past

#### Stop taking certain medicines

Please read the attached list of medicines to stop taking before your skin testing appointment.

If you take any of these medicines, you should **stop** taking them before your clinic visit. This may help us get more accurate results from you skin testing.

Before you stop taking any medicines: Be sure you get the OK to stop taking the medicine from the doctor who prescribed it.

If you have concerns about stopping your medicines, call your doctor or our clinic staff.



816 22nd Avenue, Suite 100 Kearney, NE 68845 Phone - 308-865-2263 Fax - 308-865-2541

#### **Antihistamines**

### Stop <u>7 days</u> before your test:

- Alayert (loratadine)
- Claritin (loratadine)
- Clarinex (desloratadine)
- Allegra (fexofenadine)
- Xyzal (levoceterizine)
- Atarax, Vistaril (hydroxyzine)
- Zyrtec (ceterizine)

### Stop <u>5 days</u> before your test:

- Actifed, Dimetapp (brompheniramine)
- Astelin (azelastine)
- Benadryl (diphenhydramine)
- Chlortrimetron (chlorpheniramine)
- Periactin (cyproheptadine HC)
- Phenergan (promethazine)
- Tavist, Antihist (clemastine)
- Triaminic (chlorpheniramine)

## Combination cough and cold medicines

## Stop <u>5 days</u> before your test:

- Contac
- Sine-Aid
- Dimetane
- Sinutab
- Dimetapp
- Sinutin
- Tanafed DMX
- Dristan
- Vicks Children's Nyquil
- Drixoral
- Nyguil
- Vicks Multi-Symptom/ Pediatric Cold & Cough
- Robitussin Pediatric Night Relief

## Over the counter sleep aids

## Stop <u>5 days</u> before your test:

- Nytol
- Tylenol PM
- Quita
- Twilite
- Sominex
- Unisom
- Nyquil

### Anti-nausea and anti-vertigo medicines

### Stop <u>5 days</u> before your test:

- Antivert, Bonine, DizmissR (meclizine)
- Bucdin-5 (bucitizine)
- Compazine (prochlorperazine)
- Dymenate
- Emete-Con (benzquinamide)
- Marezine (cyclizine)
- Marmine, Dramamine (dimenhydrinate)
- Tigan (trimethobenzamide)

#### **Antacid medicines**

#### Stop 1 day before your test:

- Axid (nizatidine
- Tagamet (cimetadine)
- Pepcid (famotindine) Zantac (ranitine)

## Tricyclic or tetracyclic antidepressants

## Stop 2 weeks before your test, but only after you get approval from the doctor who prescribed the medicine:

- Adepin (doxepin)
- Nopramin (desipramine)
- Anafranil (chominpramine)
- Pamelor (nortriptyline)
- Asendin (amoxipine)
- Remeron (mirtazipine)
- Avenyl (nortriptyline)
- Sinequon (doxepin)
- Chlormezanone
- Surmontil (trimipramine)
- Desyrel (trazadone) • Elavil (amitriptyline)
- Tofranil (imipramine)
- Endep (amitriptyline) Vivactil (protriptyline)
- Ludiomil (maprodine)

#### Muscle relaxants

## Stop <u>2 weeks</u> before your test:

Flexeril (cyclobenzaprine)

Name:		
DOB:		
Date: _		



	Allergy and Astillia Qu	iestionnaire
Primary Care Physician:	Dic	I he or she suggest you see us? ☐ Yes ☐ No
Clinic:	Referring doctor	l he or she suggest you see us? ☐ Yes ☐ No or (if different):
Please answer the	e questions below. If you need he	lp, we will assist you at your visit.
Check the reasons for yo	our appointment	Physician's notes
□ Nasal or sinus symptoms (	(see page 2)	•
☐ Eye symptoms (see page 2		
☐ Asthma or cough (see page		
□ Eczema (red, itchy, scaly,		
☐ Hives (see page 5)	,	
□ Food allergy (see page 5)		
□ Insect stings (see page 6)		
□ Other:		
Tell us about your home		
□ House	□ In city	
☐ Apartment or condo	☐ In country, woods or near lake	
☐ Mobile home	□ On farm	
□ Cats (how many:)	□ In suburb	
□ Dogs (how many:)	☐ Forced-air heat	
□ Birds	☐ Wood-burning stove or fireplace	
☐ Other pets:	☐ Air conditioning	
☐ Animals sleep in bedroom	□ Damp basement	
☐ Feather pillow	□ Mold growth	
□ Down comforter	□ Whole-house air cleaner	
☐ Bedroom carpet	□ Room air cleaner	
□ Cigarette smoke	☐ Mice or cockroaches	
Tell us about your social	l history	
Job:	<i>y</i>	
If patient is a child, he or sh	ne:	
☐ Lives in one home	□ Splits between homes	
☐ Goes to daycare	•	
•	s at daycare:	
	:	
Have you ever been teste	ed for allergies?	
□ Yes □ No	0	
If was whan?		
At what clinic?		

Name:	
DOB:	
Date:	



Nasal, sinus and eye symptoms			Physician's notes
Check any nasa	al or sinus symptoms yo	1 <b>y</b>	
□ Runny nose			
□ Itching			
□ Sneezing			
☐ Stuffy head or	r nose		
□ Yellow or gre	en drainage (mucus)		
☐ Drainage dow	n throat (mucus)		
□ Bleeding			
□ Ear pressure			
□ Poor sense of	smell		
☐ Sinus headach	nes		
□ Yes □ No	Have you had nasal pol	lyps?	
□ Yes □ No	Have you had sinus sur	gery? Date:	
□ Yes □ No	Have you had sinus inf		
	How many in the past y	year?	
□ Yes □ No	Have you used nasal sp	orays? Names:	
□ Yes □ No	Have you used pills for	symptoms? Names:	
Check any eve	symptoms you have:		
☐ Itching	symptoms you mave.		
□ Watering			
□ Redness			
□ Burning			
☐ Discharge or	crusting		
_	Have you used eye dro	ns? Names:	_
	Trave you used eye are	ps. rumes.	
	-		
When do nasal	, sinus or eye symptoms	s occur?	
		□ Outdoors	
□ Spring □ Summer	☐ Morning	☐ Indoors	
	□ Evening		
□ Fall □ During sleep □ All the time			
□ Winter	☐ At work or school		
What makes na	ısal, sinus or eye sympt	oms worse?	
□ Cats	☐ Mowing grass	☐ Humidity	
□ Dogs	□ Raking leaves	☐ Cigarette smoke	
□ Dust	□ Heat	☐ Scents, perfumes	
□ Exercise	□ Cold	□ Colds, infections	
□ Temperature	changes		
□ Foods:			
□ Drugs:			

Name:		
DOB:		
Date:		



Asthm	a or co	ugh symptoms		Physician's notes
Check	any sym	ptoms you have:		·
□ Whee	eze			
□ Short	ness of b	oreath		
□ Tight	chest			
□ Coug	h during	sleep		
		ough (cough with m	ucus)	
		irning in chest)	,	
	,	•	agnosed with asthma?	
		Age:		
□ Yes	□ No		ptoms as a child?	
		Age symptoms sta		
□ Yes	□ No		yed in the hospital for	
		-	ny times:	
□ Yes	□ No		the ER for asthma?	
		How many times:		
□ Yes	□ No		ednisone (a steroid pill) for	
		asthma in the past		
		How many times:		
□ Yes	□ No	Do you have hear		
□ Yes	□ No		ise you to miss any	
		school or work in	•	
		How many days:	• •	
□ Yes	□ No		nalers for symptoms?	
When o	lo asthn	na or cough sympt	oms occur?	
□ Sprin		□ Morning	□ At home	
□ Sumr	•	□ Afternoon		
□ Fall	1101	□ Evening		
□ Winte	er	□ Night	a burning exercise	
		L Tight		
□ 2111 y	Cui			
What n	nakes as	thma or cough syr	nptoms worse?	
□ Anim	nals	□ Strong	emotions	
□ Dust		□ Humid	air	
□ Smok	кe	□ Cold ai	r	
□ Food	S	□ Exercis	e	
□ Colds	s, infecti	ons □ Drugs:		
		-		

Name:	
DOB:	
Date: _	



l'ell us	about	any other	r symptoms you ar	e having	
Genera	l		□ Weight gain	□ Weight loss	□ Changes in sleep
Ears			□ Fullness	☐ Hearing loss	□ Feeling dizzy
Nose			□ Snoring	☐ Change in smell	□ Drainage
Throat.			□ Hoarse	□ Sore throat	☐ Trouble swallowing
Lungs			☐ Shortness of breath	□ Wheeze	□ Sputum (coughing up mucus)
Heart, l	blood ve	ssels	□ Chest pain	☐ Swelling of ankles	☐ Fast or irregular heartbeat
Stomac	h (GI tra	<i>ict)</i>	□ Nausea (feeling sick to stomach)	☐ Heartburn (burning in chest)	☐ Reflux (stomach acid flows back into throat)
Joints, i	muscles .		□ Joint pain	□ Stiff joints	□ Swelling of joints
Nervou	s system		□ Seizures	□ Fainting	□ Weakness
Mental	health		□ Changes in mood	□ Anxiety	
Hormon	ne chang	ges 1	□ Cannot tolerate cold	□ Cannot tolerate heat	□ Tremors
Blood			□ Bleeding	□ Bruising	
Skin an	d nails		□ Rash	□ Scaling	□ Nail changes
		dry, itch	y skin) eczema, please answer	the questions below)	
Where	does the	e eczema a	ppear?		Physician's notes
□ Sca	alp	□ Face	□ Neck		
□ Ch		□ Arms	•		
□ Ba		□ Legs	□ Feet		
□ Otl	her:				
At wha	t age di	d it start?			
What n	nakes ec	zema wor	se?		
What s	oaps do	you use? _			
□ Yes	□ No	Do you ta	ike baths?		
		-	n ·		
			se bubble bath?		
□ Yes	□ No	-	ike showers?		
		How ofte			
□ Yes	□ No		se lotions or moisturizer	rs?	
		-			
		How ofte	n:		
□ Yes	□ No	Have you	used creams or ointmen	nts	
		-	d by a doctor?		
		How ofte	n:		
□ Yes	□ No	Do you ta	ake pills to reduce the ite	ch?	
		-	r		
		II C -			

Name:	:	
DOB:		
Date:		



Hives (if you	i are concerne	ed about hives, please answer the ques	tions below)
Check any s  ☐ Wheeze ☐ Trouble so		u've had with hives:	Physician's notes
□ Tight thro	at		
□ Abdomina	al (belly) cram	nps	
□ Swelling o	of the lips, eye	elids, hands or feet	
□ Yes □ N	No Are you	under more stress than usual?	
□ Yes □ N	•	u recently taken new medicines, or minerals?	
□ Yes □ N		dose of your medicines changed?	
□ Yes □ N	No Have you	u had a recent infection?	
□ Yes □ N	No Do you l	nave contact with latex?	
□ Yes □ N	No Have you	u ever had hepatitis?	
□ Yes □ N	No Have you high thy	u or a family member had low or roid?	
□ Yes □ N	-	u or a family member had lupus or bid arthritis?	
□ Yes □ N	•	amily members have hives or episodes?	
Do any of th	nese cause hiv	ves or swelling?	
□ Heat		□ Cold	
□ Exercise		□ Stress	
□ Pressure		□ Foods	
□ Aspirin or	ibuprofen	☐ Menses (monthly periods)	
□ Other med	-	□ Other:	
Food allerg	<b>gy</b> (if you are	concerned about a food allergy, pleas	e answer the questions below)
What symp	toms occur a	fter eating a specific food?	Physician's notes
□ Hives		☐ Abdominal (belly) pain	
☐ Swelling of the throat		□ Vomiting (throwing up)	
☐ Itchy throat		☐ Diarrhea (loose, watery stools)	
□ Stuffy hea	d or nose	☐ Coughing, wheezing, shortness of breath	
□ Eczema		□ Other:	
How much	of the food do	o you eat before symptoms occur?	
How soon a	fter eating do	o symptoms occur?	

Name:	
DOB:	
Date:	



□ No	Do you know what foods cause the symptoms? If yes, list them here:	
□ No	Has the reaction required an ER visit or hospital stay? If yes, when?	
ny of the	foods listed below?	
□ yes	□ no □ haven't tried	
□ yes	□ no □ haven't tried	
-	□ no □ haven't tried	
-	□ no □ haven't tried	
-	□ no □ haven't tried	
-	□ no □ haven't tried	
-	□ no □ haven't tried	
oms occu	ar after you are stung? g □ Asthma	Physician's notes
	- 1 1	
•		
	• • • • • • • • • • • • • • • • • • • •	
ter a stin	g did the symptoms occur?	
□ No	Do you know what insect (wasp, yellow jacket, hornet, honeybee) causes symptoms? If yes, list here:	
□ No	Have symptoms lead to an ER visit or hospital stay? If yes, when:	
thing e	lse you would like the doctor to ki	10w?
	□ No  ny of the □ yes or itching to the throad other parallel or nose asects stuctured? ter a stin □ No	symptoms? If yes, list them here:  No Has the reaction required an ER visit or hospital stay? If yes, when?  yes no haven't tried yes on haven't tried yes of conscious, please a look of the stings, please a look of the parts of the throat look of the yes haven't tried yes on haven't tried yes on haven't tried yes on haven't tried yes of conscious, please a look of the stings, please a look of the yes lo