Allergy Skin Test Consent

Allergy skin testing is an important diagnostic tool used by medical providers to accurately diagnose the source of allergic reaction. Correct diagnosis through testing that identifies the specific antigens causing your symptoms is an important first step to providing you with the best and most complete range of treatment options.

By managing allergic conditions, you may reduce the number of days you miss work or school, and you may eliminate (or lessen the severity of) symptoms such as attention deficit and impaired ability to concentrate.

The skin test is performed by the same process used in an allergist's office: placement of multiple antigens on the back or other body part, to be determined by your provider, with a plastic skin test applicator. This test is extremely accurate and results are read in 15 minutes.

There is a low risk of persistent itching or discomfort, and an extremely low risk of anaphylaxis associated with skin testing.

The cost of test varies by health plan, but most health plans cover the test in-network. Please note that insurance deductibles, co-insurance and co-payments may apply. If the test is not covered by your insurance plan, you will be responsible for the cost of the test.

Please confirm that you understand the reasons for the test as well as the potential benefits and risk involved:

Date _____ Time_____

Patient Name _____

Signature of Patient or Parent/Guardian_____

Name of Parent/Guardian_____

ALLERVISION

Anaphylaxis Emergency Action Plan

Patient Name

Date of Birth

Concurrent medications

Allergies

Health problems besides anaphylaxis

Asthma? ❑ Yes (high risk of severe reaction)
❑ No

Emergency Contacts

Name

Home Phone

Cell / Work Phone

Name

Home Phone

Cell / Work Phone

Name

Home Phone

Cell / Work Phone

Office Information

Doctor Signature/Date

Doctor Phone

Patient/Guardian Signature

Date

Mild to Moderate Symptoms

- Swelling of lips, face, eyes
- Hives or welts
- Abdominal pain, vomiting

Take Action

- Stay with child and call for help
- Give medications (if prescribed)
- Locate epinepherine auto-injector
- Contact parent/carer

Watch for Anaphylaxis

Anaphylaxis (Severe Reaction)

- Difficulty/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Loss of consciousness and/or collapse
- Pale and floppy (young children)

Take Action

- Give epinepherine auto-injector
- Call ambulance: **911**
- Contact parent/carer

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? ❑ Yes ❑ No

2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

3. Do you experience symptoms of allergies? ❑ Yes ❑ No

4. Regarding possible food allergies, do you experience any of the following: (check all that apply)
   - ❑ Bloating after eating
   - ❑ Diarrhea
   - ❑ Constipation
   - ❑ Upset stomach
   - ❑ Stomach pain
   - ❑ Indigestion
   - ❑ Nausea
   - ❑ Vomiting
   - ❑ Tingling of the mouth or any other unusual sensation

Allergy Questionnaire - Part 2

To be filled out with allergy counselor after initial screening

1. What symptoms are you experiencing? (From #1 on intake form) _____
   _____
2. How often do you experience these symptoms? _____
3. Do you have any of these symptoms?

❑ Cough	❑ Runny Nose	❑ Nasal Polyps	❑ Eczema
❑ Wheezing	❑ Nasal Congestion	❑ Poor Sense of Smell	❑ Hives / Swelling
❑ Shortness of breath	❑ Itchy Nose	❑ Ear Infections	❑ Headaches
❑ Chest tightness	❑ Itchy / Watery Eyes	❑ Sinus Infections	❑ Snoring
❑ Sneezing	❑ Postnasal Drip	❑ Blocked Ears	❑ Fatigue
❑ Phlegm/sputum (Color_____)		❑ Other_____	

4. Which of the following seems to bother you or trigger/cause the above symptoms?

❑ Grass	❑ Cats	❑ Cosmetics	❑ Drafts
❑ Nervousness	❑ Hay	❑ Dogs	❑ Aerosol sprays
❑ House Dust	❑ Cold Air	❑ Mold & Mildew	❑ Horses
❑ Perfumes	❑ Smoke	❑ Humidity	❑ Basements
❑ Other Animals	❑ Insecticides	❑ Pollution	❑ Weather changes
❑ Leaves	❑ Alcoholic beverages	❑ Odors	❑ Exercise
❑ Latex (rubber)	❑ Insect bites/stings. Describe reaction:_____		

   ❑ Foods. List foods and reactions: _____
   ❑ Other. List sources and reaction: _____

5. When are your symptoms worst? ❑ Year round

❑ January	❑ February	❑ March	❑ April
❑ May	❑ June	❑ July	❑ August
❑ September	❑ October	❑ November	❑ December

6. Are symptoms better away from home? ❑ Yes ❑ No If yes, when? _____
7. Have you ever had an allergy skin test or blood test? ❑ Yes ❑ No If yes, results: _____
8. Have you ever had allergy injections? ❑ Yes ❑ No If yes, when? _____
9. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
   If yes, when? _____ How much? _____
10. Are you on allergy medications? ❑ Yes ❑ No What meds? _____
    How much? _____ For how long? _____
11. What is your occupation? (current or former) _____

THIS SECTION FOR PROVIDER AND OFFICE USE ONLY

Is patient...

❑ Suffering from uncontrolled asthma ❑ History of anaphylaxis

If yes to above, refer out to specialist

❑ On beta blocker? ❑ Pregnant? ❑ Heavily tattooed?

❑ Significantly immunocompromised or have malignancy or severe chronic illness?

If yes to above, select blood test

Wheezing or having difficulty breathing?

Experiencing active hives or extensive dermatitis?

If yes to above, treat symptoms and schedule for another day

Having symptoms consistent with food allergies?

If yes to above, consider skin panel and food panel

Indications

Inhalant Panels: ❑ Skin Test ❑ Blood Test
Food Panels: ❑ Skin Test ❑ Blood Test
Schedule skin test for (Date): _____

Patient Name Birthdate Reviewed by Date

Allergy Questionnaire - Part 3

To be filled out by patient during test development

ENVIRONMENTAL SURVEY

1. How long have you lived in your house/apartment? _____
2. Do you live in a ❑ House ❑ Apartment/duplex ❑ Condominium/townhouse
3. Approximately how old is your home? _____
4. Do you live in ❑ City ❑ Suburbs ❑ Rural area
5. Do you have a basement? ❑ Yes ❑ No
6. Type of heating: ❑ hot air ❑ steam (radiator) ❑ electric ❑ hot water (baseboard)
7. Do you have: ❑ Wood /coal stove or fireplace ❑ Humidifier ❑ Dehumidifier ❑ Air cleaner
8. Number of pets (indoor or outdoor) ____Cats ____Dogs ____Birds ____Other
9. Are there any tobacco smokers in your home? ❑ Yes ❑ No
10. Is your bedroom in the basement? ❑ Yes ❑ No
11. Do you have allergy-proof encasing for pillow or mattress? ❑ Yes ❑ No
12. What type of pillows do you have? _____
13. What type of comforter do you have? _____
14. What type of floor covering do you have in your bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor
15. How old is your mattress?_____ What's inside your mattress? (i.e. cotton/horse hair)_____
16. Do you have air conditioning? ❑ Yes ❑ No If yes, is it: ❑ Window unit ❑ Central
17. Do you have problems with roaches or mice? ❑ Yes ❑ No
18. Do you have water leaks, mold contamination? ❑ Yes ❑ No
19. Is your home/apartment excessively humid? ❑ Yes ❑ No
20. Do you experience runny nose or sneezing in response to eating? ❑ Yes ❑ No
21. Do you experience runny nose or sneezing in response to strong odors? ❑ Yes ❑ No
22. Do you experience runny nose or sneezing in response to exercise? ❑ Yes ❑ No
23. Do you experience runny nose in response to emotional upset? ❑ Yes ❑ No

MEDICAL HISTORY

1. Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic ulcer	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems/murmur	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/blood disorder	❑ Asthma	❑ Hay fever	❑ Depression
❑ Kidney/bladder disease	❑ Gynecological problems	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Glaucoma	❑ Cataracts	❑ Loss of hearing
❑ Emphysema	❑ Eczema		

2. If yes to any of above, please explain: _____
3. Have you had your tonsils or adenoids removed? ❑ Yes ❑ No
4. Have you had ear, nose or sinus surgery? ❑ Yes ❑ No
5. If yes, please explain: _____
6. Who in your family has had: (NOT including yourself)
   ❑ Asthma _____ ❑ Eczema _____
   ❑ Seasonal /year round allergies _____ ❑ Sinus problems _____
   ❑ Other allergies (drugs/bee sting/food etc) _____
7. Do you smoke? ❑ Yes ❑ No If yes, how much?_____
8. Have you smoked in the past? ❑ Yes ❑ No How long ago did you stop? _____
9. How many years did you smoke? _____

Patient Name Birthdate Reviewed by Date