

ENT SURGICAL CONSULTANTS. LTD.

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Allergy testing information packet (01/2018)

READ TODAY! This is time sensitive material. There may be medications you need to be off of for 2 weeks prior to testing.

1. Bring completed packet with you the day of allergy testing.
2. You **must** be off all antihistamines 7 days prior to allergy testing. (List included.) You should not have allergy testing within 14 days of steroid use.
3. Review list of beta blocker medications in packet prior to testing. Contact the allergy department immediately if you suspect you are on a beta blocker. (Beta blockers are used to treat high blood pressure, glaucoma and migraines.)
4. Check insurance coverage for codes: 95004-Multi-II test (1st round) and 95024 IDT (2nd round) prior to testing.
5. Please inform the Allergy Department if you are on antidepressants.
6. Wear sleeveless or short sleeve top to testing, and don't let your arms get sunburned prior to testing.
7. Bring list of medications you are currently taking.
8. Eat prior to testing. Be on time and allow at least 60 minutes.
9. Appointments not cancelled within 10 days will be assessed a \$50 fee.
10. Contact the allergy department at 815-531-3804 if you have any questions.

Insurance Information

You are responsible for notifying your insurance company before your scheduled test. Failure to do this can result in non-payment of your claims. (This does not apply to Medicare). Patients with HMO (Health Maintenance Organization) or a POS (Point of Service) **are required** to contact their primary care physician to obtain the mandatory referral. We are NOT credentialed with NAMM for HMO allergy therapy.

We will submit your allergy testing to your insurance, provided correct insurance information is given to us. Any unpaid balances are your responsibility. SLIT (allergy drops) do not have an approved insurance code, and therefore are not covered by insurance.

All patients will be required to pay the insurance co-payment at the time of the test. If shots are indicated, the cost of the injection is due at each visit.

If you have any questions, please contact our insurance department at (815) 725-9583.

I have read the above information and understand the insurance policy.

Patient or Guardians signature

Date

ENT Surgical Consultants

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ALLERGY HISTORY QUESTIONNAIRE (01/2018)

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Referring MD: _____

Present Symptoms: _____

Have you had any treatments for this? _____

Please list your current medications: _____

What is your occupation: _____

Do you live in a home, townhome, apartment, other? _____

What is the approximate age of your current residence. _____

Do you have pets? Describe: _____

What kind of hobbies or recreational activities do you like to do? _____

Do you smoke? Y N Do you live with a smoker? Y N Does smoke bother you? Y N

Do you have any allergies to medication? List _____

Ears

- | | |
|---|---|
| Y N Do you have permanent hearing loss in one or both ears? | Y N Do you wear a hearing aid? |
| Y N Do you have drainage from one or both ears? | Y N Do you have any ear pain? |
| Y N Do you have Ringing in one or both ears? | Y N Do you experience dizziness? |
| Y N Are you bothered by itching or eczema of the ears? | Y N Do you experience fullness or popping in ears |
| Y N Do you get frequent middle ear infections? | |

Eyes

- | | |
|--|---|
| Y N Are you bothered by itching eyes? | Y N Do your eyelids become red and swollen? |
| Y N Do you have puffiness or dark circles under your eyes? | Y N Do you get eczema around your eyes? |
| Y N Do you have glaucoma? | Y N Are you bothered by watery eyes? |
| Y N Are you bothered by burning eyes/ | |

Nose

- | | |
|--|---|
| Y N Do you have drainage? Color _____ | Y N Do you have post nasal drip? |
| Y N Do you frequently bow your nose? _____ X per day | Y N Do you have fits of sneezing/ |
| Y N Does the inside of your nose itch often? | Y N Have you ever had nasal polyps removed? |
| Y N Do you use nasal sprays often? | Y N Does your nose become stuffy a lot? |
| Y N Do you have any loss of smell? | Y N Do you have any nasal obstructions? |
| Y N Have you had nasal or sinus surgery? | Y N Do you get frequent sinus infections? |

Mouth/Throat

- | | |
|--|--|
| Y N Do your lips swell at times? | Y N Do you have itching of the palate or throat? |
| Y N Are you troubled by cold sores? | Y N Do you clear your throat a lot? |
| Y N Does your tongue get swollen, reddened or sore at times? | Y N Do have choking sensations? |
| Y N Are you bothered by bad breath? | Y N Do you wake up with a dry throat? |
| Y N Do you have frequent sore throats? | Y N Do you have difficulty swallowing? |
| Y N Are you bothered by hoarseness? | Y N Do the glands in your neck become swollen often? |
| Y N Do you get oral thrush frequently? | |

Name: _____

Head

- | | |
|--|---------------------------------|
| Y N Do you have headaches due to sinus problems? | Y N Are you tired all the time? |
| Y N Have you ever had a migraine headache? | |
| Y N Do you have frequent headaches? If yes, how often _____ | |
| Y N Does anything make your headaches worse? List _____ | |
| Y N Are your headaches worse at the same time of day? When _____ | |
| Y N Are your headaches limited to any certain part of your head? Where _____ | |
| Y N Do you take medication for headaches? If yes, please list _____ | |

Chest

- | | |
|---|-------------------------------|
| Y N Do you have a chronic cough? Dry/ Congested | Y N Do you have asthma? |
| Y N Do you have frequent or chronic bronchitis? | Y N Do you use an inhaler? |
| Y N Are you short of breath? | Y N Do you have night sweats? |

Gastrointestinal

- | | |
|---|--|
| Y N Do you often belch after meals? | Y N Do you have bloating after meals? |
| Y N Do you have colitis? | Y N Do you have attacks of diarrhea after meals? |
| Y N Do you suffer from constipation? | Y N Do you have distress or indigestion after meals? |
| Y N Do you have anal itching? | Y N Are you often drowsy after meals? |
| Y N Are there any foods that disagree with you? If yes, please list _____ | |

Genitourinary

- | | |
|---|---|
| Y N Do you have frequent vaginitis or "yeast infections"? | Y N Do you have frequent jock itch? |
| Y N Are you pregnant now? | Y N Do you plan on pregnancy within the next few years? |

Skin, Joints and Muscles

- | | |
|--|--|
| Y N Are you troubled by acne? | Y N Are you prone to hives? |
| Y N Do you feel cold all the time? | Y N Do you have joint pain and swelling that fluctuates? |
| Y N Are your fingernails fragile, splitting and peeling? | Y N Do you have fungus on your hands or feet? |
| Y N Do you have arthritis? If yes, where _____ | |
| Y N Do you have eczema? If yes, where _____ | |
| Y N Do you have psoriasis? If yes, where _____ | |

Childhood History

- | | |
|--|--|
| Y N Did you have infant eczema? | Y N Did you have colic as an infant? |
| Y N Where you hyperactive as a child? | Y N Did you have asthma as a child? |
| Y N Did you have frequent ear infections? | Y N Did you have frequent or chronic coughs? |
| Y N Did you suffer from stomach aches, vomiting or diarrhea? | |

Family History (Have your parents or siblings had any of these)

- | | |
|-----------------------------|----------------|
| Y N Asthma? | Y N Hayfever? |
| Y N Chronic sinus problems? | Y N Migraines? |

Environmental History

- | | |
|--|--|
| Y N Do you have mattress, boxspring & pillow allergy covers? | Y N Are you exposed to excessive amounts of dust? |
| Y N Are your symptoms worse while dusting your house? | Y N Are symptoms better when you are away from home? |
| Y N Are your symptoms worse after vacuuming the house? | Y N Do you have air conditioning at home? |
| Y N Do you sleep with a pillow? What type _____ | Y N Do you have air conditioning at work? |
| Y N Are you worse during a particular season? List _____ | Y N Is your mattress cotton? If no, what _____ |

Mold History

- | | |
|--|--|
| Y N Are your symptoms worse when mowing the lawn? | Y N Are your symptoms worse when raking leaves? |
| Y N Are your symptoms worse when in a damp basement? | Y N Are your symptoms worse in damp weather? |
| Y N Are your symptoms worse after drinking beer? | Y N Are your symptoms worse after eating cheese? |

Chemical Exposure

- | | |
|--|---|
| Y N Are you exposed to excessive amounts of chemicals? | Y N Are your symptoms worse in city air pollution? |
| Y N Are your symptoms worse when exposed to paint fumes? | Y N Do you have a gas stove? |
| Y N Do you have a gas furnace? | Y N Do you have an oil furnace? |
| Y N Are you worse when around wood smoke? | Y N Are symptoms worse after using powders/perfume? |
| Y N Are you bothered by other people's perfume? | Y N Are your symptoms worse in a beauty/barber salon? |

ENT Surgical Consultants

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Scott DiVenere, MD Sung Chung, MD Ankit Patel, MD

Consent for Allergy Testing & Beta Blocker Check List (03/2013)

Patient Name: _____ (Print Name) DOB: _____

YOU MAY NOT BE TESTED IF ON ANY OF THESE MEDICATIONS. CALL 815-531-3804 IMMEDIATELY!!
Beta Blocker Check List --THIS LIST IS NOT ALL-INCLUSIVE. PLEASE CALL IF YOU HAVE QUESTIONS.

Acebutolol HCL (Sectral)	Inderide	Pindolol (Visken)
Atenolol (Tenormin)	Inderide LA	Propranolol
Atenolol/Chlorthalidone (Tenoretic)	Innopran XL	Propranolol Hydrochloride
Betapace	Kerledex	Propranolol HCL
Betapace Af	Kerlone	Sectral
Betaxolol	Labetolol HCL (Trandate, Normodyne)	Sorine
Betaxolol HCL (Kerlone)	Labetolol/Hydrochlorothiazide (Normozide)	Sotalol (Betapace)
Bisoprolol (Zebeta)	Levatol	Sotalol HCL
Bisoprolol Fumarate (Ziac)	Lopressor	Tenoretic
Blocadren	Lopressor HTC	Tenormin
Brevibloc	Metoprolol	Tenormin I.V.
Bystolic	Metoprolol Succinate (Toprol XL)	Timolide
Carteolol	Metoprolol HCL (Lopressor)	Timolol
Carteolol HCL (Cartrol)	Metoprolol Tartrate	Timolol Maleate (Blocadren)
Cartrol	Nadolol (Corgard)	Timolol Maleate/Hydrochlorothiazide
Carvedilol	Nadolol & Bendroflumethiazide (Corzide)	Toprol
Coreg	Nebivolol	Toprol XL
Corgard	Nebivolol HCL	Trandate
Corzide	Nebivolol Hydrochloride	Trandate HCL
Esmolol	Normodyne	Trandate + HCT
Esmolol HCL (Brevibloc)	Normozide	Visken
Inderal	Penbutolol	Zebeta
Inderal LA	Penbutolol Sulfate (Levatol)	Ziac

Topically Applied Beta Blockers

Betaxolol (Betoptic)	Levobunolol (Betagan)	Timolol (Timoptic)
Carteolol (Ocupress)	Metripranolol (Optipranolol)	

MAO Inhibitors

Phenelzine Sulfate (Nardil)	Tranylcypromine (Parnate)
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_____ I have read the above list and am not currently taking any medications on the list.

_____ I have reviewed the above list and am currently on _____.

I understand that I need to let this office know if I start additional medications in the future, since it may affect my allergy testing and treatment.

I authorize the above named patient to receive allergy skin testing. I understand that the purpose of the testing is to produce an observable or detectable reaction in order to determine the type and degree of allergy for the patient tested. I further understand that there is a small risk of a more serious reaction from any allergy skin testing.

Patient or Guardian Signature: _____ Date: _____

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ALLERGY RELIEF MEDICATIONS (08/2013) IMPORTANT MEDICATION INSTRUCTIONS

You **must be off all antihistamines for at least 7 days** before your test. Antihistamines are allergy relief medications and WILL interfere with the results of your skin testing. Antihistamines are available over-the-counter and by prescription.

Please notify the ENT allergy department if you are taking any oral steroids, anti-depressants, or high blood pressure/cardiac type medications.

Asthma patients: please bring emergency rescue inhaler with you the day of testing.

~ **DO NOT take medications listed in the 3 boxes below for AT LEAST 7 DAYS prior to testing** ~

Acrivastine Allegra® Antivert® Atarax® Benadryl® Carbinoxamine Maleate Chlorpheniramine Maleate Chlor-Trimeton® Clarinex® Clariten® Cyproheptadine Dimetane Diphenhydramine Doxepin hydrochloride Dramamine Dymista®	Meclizine hydrochloride Midol® Complete Optimine Pataday® (eye drops) PBZ Periactin® Phenergan® Polaramine Pripelennamine R-Tanna Sinequan Tavist® Temaril Thorazine® Vistaril® Xyzal® Zyrtec®	Over-the-counter sleep aids Appetite suppressant/ diet medications Medications with the words “allergy relief” or “PM”, such as: <ul style="list-style-type: none">• Tylenol PM®• Tylenol Sinus and Allergy®• Excedrin PM® Do not take the following 24 hours prior to testing: <ul style="list-style-type: none">• Tagamet• Pepcid• Axid• Zantac• Other acid reflux medications Do not take the following nasal sprays for at least 7 days prior to testing: Astapro®, Asteline®, Dymista®, Patanase®
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~ **You MAY CONTINUE to take all other medications you have been taking, including those listed below** ~

Sudafed® or pseudoephedrine (as long as there is no history of high blood pressure) **NOTE: Sudafed with antihistamine should NOT be taken. The following steroid nasal sprays are okay to continue taking: (Afrin®, Flonase®, Nasonex®, Omnaris®, Qnasl®, Rhinocort®, Veramyst®, Zetonna®, etc.) Guaifenesin (Robitussin®, Mucinex®, Humbid®, etc.) Pain medications – OTC and prescription (Single compound - Tylenol®, Excedrin®, Aleve®, Motrin®, aspirin)	Leukotriene modifiers (Singular®, Accolate®) All Asthma medications (Advair®, Albuterol, Atrovent®, Combivent®, Pulmicort®, etc.) If you need to use a nebulizer for acute symptoms within 24 hours prior testing, please call allergy department after use.
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ALLERGY SUPPORT RESOURCES (03/2013)

Allergy & Asthma Network

Mothers of Asthmatics, Inc. Phone: 800-878-4403

For more information about allergies, asthma, and environmental control for a healthy home.

Allergy & Asthma Information Center & Hotline

Phone: 800-727-5400

For more information about allergies, asthma, and environmental control for a healthy home.

Allergy Asthma Technology, Ltd.

Phone: 800-621-5545, Fax: 847-966-3068, Web: <http://www.allergyasthmatech.com>

Full line of Allergy and asthma home products.

American Academy of Allergy and Immunology

Phone: 800-822-2762

For more information about allergies, asthma, and environmental control for a healthy home.

American Academy of Environmental Medicine

Phone: 913-648-6062

For more information about allergies, asthma, and environmental control for a healthy home.

American College of Allergy & Immunology

Phone: 800-842-7777

For more information about allergies, asthma, and environmental control for a healthy home.

American Lung Association

Phone: 800-586-4872 Web site: www.lungsusa.org

For more information about allergies, asthma, and environmental control for a healthy home.

Allergy Control Products, Inc.

Phone: 800-422-3878, Fax 203-431-8963 Web site: www.allergycontrol.com

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