Mid-Michigan ENT | ALIGN ENT+ Allergy Partner

What Do I Need To Do Before My Allergy Test?

Date of my Allergy Test_____**Time**_____
If you cancel your testing, you must inform the clinic at least 72 hours prior to your scheduled appointment, otherwise a $100 no-show fee will be charged.

Discontinue appropriate medications
- You must **STOP** taking medication with **antihistamines 7 days** prior to testing – this includes pills, eye drops, and nasal sprays that contain antihistamines.
- We **CANNOT** do allergy testing if you are on a **beta blocker** – please DO NOT stop taking your beta blocker without contacting your prescribing provider.
- Attached is a list of **medications** that must be **discontinued** prior to allergy testing.
- You **CANNOT** receive any **vaccinations** within **48 hours prior** to allergy testing.

Complete questionnaire
Please complete the attached allergy questionnaire and bring it with you on the day of testing.

Dress appropriately
- Please wear a **short-sleeved shirt** because testing is usually done on your arms.
- Young children should also wear shorts because testing may be done on the legs.
- Please do not wear perfumes, body scents, or lotion on the day of testing.

Eat a snack
Be sure to eat or drink something prior to your allergy testing.

Need to reschedule?
Call us 72 hours prior to your testing to cancel or reschedule your allergy test.

Questions about allergy testing?
If you have questions after reading this handout, please call us at 517-332-0100 Ext. #110.

What happens on the day of testing?
- Anticipate your test taking about 60 minutes.
- Allergy team will review your medications and your allergy questionnaire.
- Allergy team will perform Skin Prick Testing and Intradermal Testing.
- Allergy team will give you the results of your allergy testing.
- Expect to follow-up with one of our medical providers to discuss your allergy test.
- We test 34 allergens including
  Cat • Dog • Dust Mite • Grasses • Trees • Molds • Cockroaches

Medication Discontinuation List

You must **STOP** taking medication with **antihistamines 7 days** prior to testing – this includes pills, eye drops, and nasal sprays that contain antihistamines. *Check with your prescribing or primary care provider to make sure it's okay to stop these medications.*

STOP 7 DAYS BEFORE TESTING

Antihistamine Medications		Antihistamine-Containing Eye Drops and Nasal Sprays
Acetifed Cold & Sinus	Levoceterizine	Astelin (Azelastine Nasal)
Advil Cold & Sinus	Loratidine	Astepro (Azelastine Nasal)
Accuhist	Meclizine	Elestat (Epinastine Ophthalmic)
Alavert	Naphcon	Levostin (Levocabastine Ophthalmic)
Allegra	Napholazine	Optivar (Azelastine)
Antivert	Nyquil	Patanase (Olopatadine Nasal)
Atarax	Olopatadine	Patanol (Olopatadine)
Azelastine	Optimine	Pataday (Olopatadine)
Azatadine	Pazeo	Zatidor (Ketotifen Fumarate)
Benadryl	Pepcid	
Chlorpheniramine	Periactin	
Ceterizine	Phenergen (Promethazine)	
Cimetidine	Pyrlex (Pyrilamine)	
Clarinex	Quintadrill	
Claritin	Ranitidine (Zantac)	
Cyproheptadine	Sinulin	
Cyprohephydramine	Sinequan	
Desloratadine	Tagament	
Diphenhydramine	Trazadone	
Doxepin	Tylenol PM	
Doxylamine	Tylenol Cold/Tylenol Flu	
Dymista	Unisom	
Famotadine	Vicks	
Fexofenadine	Vistaril	
Hydroxyzine Hydrochloride	Xyzal	
Ketotifen	Zyrtec	

Medication Discontinuation List

We **CANNOT** do allergy testing if you are on a **Beta Blocker.** *Please **DO NOT** stop taking your Beta Blocker without contacting your prescribing provider first.*

STOP 7 DAYS BEFORE TESTING

Beta Blocker Medications		**Beta Blocker Eye Drops**
Atenolol	Levatol	AK Beta
Betapace	Lopressor	Betagan
Bisoprolol	Metoprolol	Betoxolol
Brevibloc	Nadolol	Betopic
Bystolic	Pindolol	Cartelol
Carvedilol	Propanolol	Kerlone
Coreg	Sectral	Levobunolol
Corgard	Sotalol	Metipanolol
Corzide	Tenoretic	Octipranolol
Esmolol	Tenormin	Ocupress
Indernal	Timolide	Timolol
Innopran	Toprol	Timoptic
Cyproheptadine	Toprol XL	Zatidor
Kerlone	Trandate	
Desloratadine	Zebeta	
Labetalol	Ziac	

Some medications for **psychiatric** or **sleep conditions** disrupt the success of allergy testing and should be temporarily discontinued for best results**.** *Contact your prescribing provider before discontinuing.*

STOP 7 DAYS BEFORE TESTING

Psychiatric or **Sleep Medications**		
Ativan	Desloratadine	Remeron
Alprazolam	Elavil	Restoril
Ambien	Escitalopram	Robaxin
Amitriptyline	Eszopiclone	Seroquel
Buspar	Klonopin	Skelaxin
Busprinone	Lorazepam	Temazepam
Celexa	Lunesta	Tinazidine
Citalopram	Mirtazapine	Valium
Clonazepam	Nortriptyline	Wellbutrin
Cyclobenzaprine	Oleptro	Xanax
Cyproheptadine	Pamelor	Zanaflex
Diazepam	Quetiapine	Zolpidem

Medication Discontinuation List

Below is a list of topical corticosteroids that must be discontinued 21 days prior to your allergy testing. These medications can decrease the accuracy of the allergy test. This list is not comprehensive.

STOP 21 DAYS BEFORE TESTING

Topical Corticosteroids		
Aclovate	Dermarest	Mi-Cort
Ala-Cort	Dermasorb	Nolix
Ala-Scalp	Dermatop	NuCort
Alphatrex	Dermovate	Nutracort
ANucort	Dermtex	Olux
Anumed	Desonate	Oralone
Anusol-HC	DesOwen	Pandel
Apexio	Diprolene	Pediaderm
Apexicon-E	Deiprolene	Preparation-H
Aristocort	Diprosone	Procto-Kit
Beta-Val	Elocon	Proctocort
Betacort	Embeline	Proctozone
Betamethasone	Florone	Psorcon
Betamethacot	Fluocinonide	Rectacort
Betnovate	Flurosyn	Sarnol
Caldecort	Gly-Cort	Scalacort
Capex	Gynecort	Scalp-Cort
Carmol	Halog	Synalar
Cetacort	Halonate	Temovate
Cinolar	Hemmorex	Texacort
Clobevate	Hemorrhoidal-HC	Topicort
Clobex	Hemril	Triacet
Clodan	Hytone	Trianex
Coraz	Instacort	Triamcinolone
Cormax	Itch-X	Tridesilon
Cortaid	Kenalog	U-Cort
Corticaine	Keratol	Ultravate
Cortizone	Lacticare	Valisone
Cotacort	Lidex	Vanos
Cutivate	Locaid	Verdeso
Cyclocort	LoKara	Wescort
Del-Beta	Luxiq	
Derma-Smooth	Maxiflor	

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Mid Michigan ENT Allergy Questionnaire

If you have taken antihistamines in the last 7 days we CANNOT do your test today

Name_____Date of Birth_____

Symptoms

When did your symptoms begin? _____ Are your symptoms getting worse? ☐ Yes ☐ No

Please check any of the following symptoms you have:

EYES ☐ itchy ☐ watery ☐ redness ☐ swelling ☐ crusting ☐ dryness ☐ burning
☐ dark circles ☐ blurred vision

EARS ☐ itchy ☐ popping ☐ congestion ☐ ear infections ☐ PE tubes
☐ earache ☐ hearing loss ☐ middle ear fluid ☐ blocked ears

NOSE ☐ itchy ☐ sniffling ☐ watery discharge ☐ cloudy discharge ☐ congestion
☐ nosebleeds ☐ broken nose ☐ loss of smell/taste ☐ dryness ☐ nasal polyps
☐ snoring ☐ sneezing ☐ sinus infections

MOUTH/THROAT ☐ none ☐ sore throat ☐ hoarseness ☐ itchy throat ☐ postnasal drip
☐ difficulty swallowing ☐ swollen gland ☐ mouth breathing

HEADACHE ☐ none ☐ infrequent ☐ frequent ☐ occur with sinus infections ☐ sharp
☐ dull ☐ pounding ☐ facial ☐ forehead ☐ temples ☐ back of head

CHEST ☐ cough ☐ tightness ☐ congestion ☐ wheezing ☐ shortness of breath ☐ pain
☐ soreness ☐ sputum

SKIN ☐ none ☐ dryness ☐ hives ☐ swelling ☐ itching ☐ eczema ☐ rashes
Sensitivity to ☐ chemicals ☐ metals ☐ cosmetics

Have you ever had hives or an anaphylactic reaction (difficulty breathing, throat swelling) after eating a certain food? ☐ Yes ☐ No If yes, what food(s)? _____

Do foods cause you to have diarrhea, gas, heartburn, nausea, vomiting, and/ chronic abdominal pain?
☐ Yes ☐ No If yes, what food(s)? _____

Please check ALL months when your symptoms are bad:
☐ Every month ☐ January ☐ February ☐ March ☐ April ☐ May ☐ June
☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Are your symptoms worse ☐ indoors ☐ outdoors ☐ at home ☐ at work ☐ morning ☐ evenings

Do you have to miss school or work because of allergies? ☐ Yes ☐ No If yes, frequency_____

Do your symptoms disturb your sleep? ☐ Yes ☐ No

Medical and Social History

Please list all medications you have used to treat allergy symptoms_____

_____

Has asthma ever been diagnosed? ☐ Yes ☐ No

Have you ever been tested for allergy previously? ☐ Yes ☐ No

Have you had allergy shots before? ☐ Yes ☐ No If yes, did they help? ☐ Yes ☐ No

Have you ever had a reaction to an allergy shot? ☐ Yes ☐ No

Have you had any severe reactions to immunizations? ☐ Yes ☐ No
If yes, what?_____

Have you had an allergic reaction to any medication? ☐ Yes ☐ No
If yes, what?_____

Have you been hospitalized for allergy problems? ☐ Yes ☐ No

Have you had any of the following operations ☐ tonsillectomy ☐ adenoidectomy ☐ nasal septum repair

☐ sinus surgery ☐ tubes in ears ☐ removal of nasal polyps ☐ chest surgery ☐ transplant surgery

Do you smoke or have you ever smoked? ☐ Yes ☐ No
If yes, for how long and how much _____

Do you or others smoke in the house: ☐ Yes ☐ No

Women of childbearing age: Are you pregnant, trying to conceive, or nursing a baby? ☐ Yes ☐ No

Do any blood relatives have known allergy problems or asthma? ☐ Yes ☐ No
If yes, please list_____

How long have you lived in Mid-Michigan?_____

Please list other areas of residence_____

Do you live in a ☐ house ☐ apartment ☐ mobile home ☐ other_____

Home located in or by ☐ residential area ☐ fields ☐ farms ☐ factories ☐ lakes or marshes

Do you have any pets? ☐ Yes ☐ No
If yes, what kind_____ Are they indoors? ☐ Yes ☐ No

Please list your current work environment _____

Are you exposed to anything at work or school which aggravates your condition? ☐ Yes ☐ No

If yes, please list_____

Signature_____

Sino-Nasal Outcome Test (SNOT-20) Questionnaire

Name_____Date of Birth _____

• Consider how severe the problem is when you experience it ond how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel. • Please mark the most important items affecting your health (maximum of 5 items).	No Problem	Very Mild Problem	Mild or slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be		Most important symptoms
1. Need to blow nose	0	1	2	3	4	5		☐
2. Sneezing	0	1	2	3	4	5		☐
3. Runny nose	0	1	2	3	4	5		☐
4. Cough	0	1	2	3	4	5		☐
5. Post-nasal discharge	0	1	2	3	4	5		☐
6. Thick nasal discharge	0	1	2	3	4	5		☐
7. Ear fullness	0	1	2	3	4	5		☐
8. Dizziness	0	1	2	3	4	5		☐
9. Ear pain	0	1	2	3	4	5		☐
10. Facial pain / pressure	0	1	2	3	4	5		☐
11. Difficulty falling asleep	0	1	2	3	4	5		☐
12. Wake up at night	0	1	2	3	4	5		☐
13. Lack of sleep	0	1	2	3	4	5		☐
14. Wake up tired	0	1	2	3	4	5		☐
15. Fatigue	0	1	2	3	4	5		☐
16. Reduced productivity	0	1	2	3	4	5		☐
17. Reduced concentration	0	1	2	3	4	5		☐
18. Frustrated / restless / irritable	0	1	2	3	4	5		☐
19. Sad	0	1	2	3	4	5		☐
20. Embarrassed	0	1	2	3	4	5		☐