This office is dedicated to providing the best quality allergy care. Your understanding of our office policies and practices will help us to help you.

Our Staff
Doctors, Bell, Lee, Shah, Dave and Godhwani are Board Certified Allergists. They have completed approved specialty training in Allergy and Clinical Immunology, and have passed a certifying examination by the American Board of Allergy and Immunology. All of our nurses have experience in general nursing as well as special training in allergy. Our medical receptionists and our insurance specialists are knowledgeable in their fields and eager to help. We are all interested in making your treatment as pleasant and effective as possible.

Office Hours
All visits are by appointment only. Please note, our schedules vary by location.

Appointments and Policies
- We respect your time and make every effort to minimize waiting time by scheduling appointments carefully. Please assist us by arriving 15 minutes prior to your appointment in order to allow the receptionist and nurse to complete their tasks before your scheduled time with the doctor. Your understanding is appreciated on those occasions when circumstances cause a delay in our schedule.

- It is imperative that you refer to the Medications list within this packet prior to your appointment for instructions on withholding medications that may affect testing that is recommended by your doctor.

- For the initial visit, expect to be in the office for up to 2 hours as testing may be performed based on your physician evaluation.

- If your appointment needs to be rescheduled or cancelled, please notify the office at least 24 hours in advance. Patients not demonstrating this consideration will be charged $25-$50 for each missed appointment and may not be allowed to reschedule appointments in the future.

- Cell phone conversations are disturbing to others. Please turn off your cell phone while in our office.

- Parents are responsible for the behavior of their children in this office. Please supervise your child’s quiet play.
• FOR THE SAFETY OF OUR PATIENTS WITH FOOD ALLERGIES, PLEASE DO NOT BRING FOOD OR BEVERAGES (OTHER THAN WATER) INTO THE OFFICE.

Insurance and Payments
Our office participates with many -- but not all - insurance plans. We also accept Medicare assignment. For plans with which we participate, your obligation is to pay any applicable deductible and/or co-payment at the time of your visit.

It is your responsibility to obtain any referrals or pre-authorizations required by your plan. Please note that our checking that a referral has been made and that benefits have been "verified" does not assure that your policy is in force. If the policy is not in force, you are responsible for the charges.

If you are enrolled in an insurance plan with which we do not participate, fees are your responsibility and payment is due at the time of your visit. In such cases, our office has a financial relationship with you, not your insurer, and any insurance reimbursement will be made from your insurance company directly to you.

We accept cash, check or MasterCard/Visa/Discover as method of payment. Please let us know if a financial hardship exists.

Emergency Coverage
Our physicians can be reached through the answering service for evening or weekend allergy emergencies. If they are not available, another Board Certified allergist is almost always on call for coverage. Please note that on a very few occasions our physicians and the backup allergists may be unavailable and will recommend a pediatrician or internist to the answering service.

Please note that routine prescription refills will not be given after regular office hours. Please check your supplies and obtain refills before you run out. Telephone refills will not be given to patients who are overdue for follow-up appointments.

Confidentiality
Your medical records are strictly private. No information regarding your condition will be given to employers, friends, relatives, insurance companies or other physicians without your consent.

Doctor-Patient Relations
A relationship of mutual respect and understanding must exist among physician, staff and patient. We make a special effort to explain fully all aspects of your condition and treatment. Please ask for further information if any aspect is not clear to you or if you have any questions.

Likewise, if you have any suggestions or complaints regarding our services or fees, please tell us.

In Conclusion
It is our sincere desire to provide you with the best medical care possible. We hope this information will help you to understand how our office functions, and we trust that our relationship will be a pleasant and productive one.
PATIENT REGISTRATION
If the Patient Is a Child, Fill Out the Information as It Pertains to the Child

Date: __________________________

Patient First Name: __________________ Last Name: __________________ M.I.: __________________

☐ Male ☐ Female

Date of Birth: ___/___/____ Age: ______ Social Security #: _______ _______ _______

Street: __________________________ City: __________________ State: ______ Zip: ______

Home Tel: # (_____): ___________ Business Tel: # (_____): ___________ Cell Phone #: ___________

Select ONE contact method for appointment reminders? Email: ☐ Text: ☐ Call: Home ☐ Work ☐ Cell ☐

EMAIL ADDRESS: ____________________________

Primary Doctor: __________________________ Location (City/State): __________________________

Was this your referring physician? ☐ NO ☐ YES If No, Who was your referring provider? __________________________

Information needed for governmental compliance:

Race: White ☐ African American ☐ Asian ☐ Multi-racial ☐ Refuse to answer

Preferred Language: English ☐ Spanish ☐ Refuse to answer

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to answer

How did you hear about our practice? PLEASE CIRCLE ONE:

ASC Website / Attorney / Danbury Hosp Website / Email / Facebook / Friend or Family / Google / Healthy Hearing / Hospital ER / Instagram / Insurance Company / School Newspaper or Magazine / Online / Physician / Radio or TV / Twitter / Yellow Pages

Responsible Parent/Guardian: __________________________ Parent/Guardian Date of Birth: ___/___/____

Parent/Guardian Phone: ___________ Street: __________________ City: __________________ State: ______ Zip: ______

Emergency Contact Name: __________________________ Relationship: __________________________

Home Tel: # (_____): ___________ Cell #: ___________

☐ By checking, you authorize Advanced Specialty Care to discuss your medical information with the emergency contact listed above.

If your insurance plan requires an insurance authorization referral to this office, you must have this referral at the time of your visit, or full payment will be expected.

It is your responsibility to ensure your authorization referral is current and on file in this office prior to seeing the physician for all visits, including follow-ups. There are NO exceptions to the office referral policy.

*HSA POLICY: If you have a health savings account insurance plan, and your deductible has not been met, we request payment at time of service. For self-pay patients and those with HSA policies, payment is expected at time of service and a payment plan can be discussed with our billing department if needed**Your office visit can range anywhere from $150-$375, to additional testing ranging from $200-$800.

IS TODAY’S VISIT RELATED TO AN INJURY, ACCIDENT OR 3rd PARTY PAYER? ☐ NO ☐ YES

PRIMARY INSURANCE COMPANY INFORMATION

Insurance must be filled in completely, even if we copy your insurance card.

Ins. Co. Name: __________________________ Plan: __________________

ID #: ___________________________ Group Name or Number: __________________________

Policy Holder’s Name: __________________ Relation to patient: __________________

Sex: ☐ Male ☐ Female Date of Birth: ___/___/____ Social Security #: __________________________

SECONDARY INSURANCE COMPANY INFORMATION

Ins. Co. Name: __________________________ Plan: __________________

ID #: ___________________________ Group Name or Number: __________________________

Policy Holder’s Name: __________________ Relation to patient: __________________

Sex: ☐ Male ☐ Female Date of Birth: ___/___/____ Social Security #: __________________________

PUBLIC FORMS: Reception/CURRENT New demographic form 2015.CURRENT
ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:
Notice of Privacy Practices  Informed Consent
Practice Financial Policies
ADVANCED SPECIALTY CARE

107 Newtown Road, Danbury, CT 06810  901 Ethan Allen Highway, Ridgefield, CT 06877
131 Kent Road New Milford, CT 06776  22 Old Waterbury Road, Southbury, CT 06488
488 Main Ave, Norwalk, CT 06851

Privacy Officer: Jennifer Reiter, Privacy Officer (203) 830-4700 ext. 8265

I hereby acknowledge that I was given the opportunity to review this medical practice’s Notice Of Privacy Practices (HIPAA), and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the person(s) listed below to discuss my medical information.

<table>
<thead>
<tr>
<th>Name &amp; phone number</th>
<th>Relationship to Patient</th>
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Due to HIPAA laws, we are unable to leave medical information on your voicemail, send it by e-mail or leave it with a member of your family. We are unable to discuss your medical care with anyone unless you authorize to do so. It is for that reason that we are having you give us authorization via this form.

I authorize ASC providers to leave medical information pertaining to my care including test results by the following methods and will assume responsibility of notifying the office whenever this information changes. Please checkmark below all that applies.

Home Telephone/Answering Machine  Yes □  No □
Cell Phone                         Yes □  No □

☐ I hereby authorize Advanced Specialty Care to correspond with me/authorized persons via email regarding my medical care.

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, other diagnostic test results, and/or medication history from outside facilities in order to provide treatment. At times these facilities may require an authorization to release such records. My signature authorizes the release of these records.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

I understand that I will be charged a $25-$50 NO-SHOW fee if I do not show up at my scheduled appointment. In order to avoid the NO-SHOW fee an appointment needs to be cancelled 24 hours prior.

If this office does not have a contract with my insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited.

Signature (Parent or Guardian please sign if Patient a Minor)

Please Print Name

Relationship to Patient

Date /

Patients Name (if Minor)

PATIENT'S SIGNATURE Date

P32175038

P32775038

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF 32775038.doc
Please list all medications you are currently taking and dosage (Include prescriptions, non-prescriptions, herbal supplements, etc.)

1. 
2. 
3. 
4. 
5. 
6. 
7. 

Allergies to medication: Drug name/Reaction

_________________________ _________________________
_________________________ _________________________

Latex Allergy □ Yes □ No
Advanced Allergy & Asthma Care

Name ___________________________ D.O.B ___________________________ Date ___________________________

Please circle the reason(s) for your visit today:

Nose symptoms  Hives or Swelling  Food Allergy
Asthma  Cough  Drug allergy
Eczema  Insect Sting Allergy  Other

There are many sections below, please fill out the sections for which you have symptoms:

IF YOU HAVE ASTHMA SYMPTOMS:

Have you been diagnosed with Asthma?  Yes  No

If so, at what age?  ______

Have you had any hospitalizations or ER visits for asthma?  Yes / No. If yes, list approximate dates:

________________________________________________________________________

Have you been treated with oral steroid pills/liquid (eg: prednisone, medrol, prednisolone) for asthma?  Yes / No

How many courses of steroids in the past one year?  __________

Have you ever been prescribed any of the following inhalers? (Please circle)

Advair / Symbicort / Dulera / Flovent / Asmanex / QVAR / Pulmicort / Alvesco / Other  __________

What symptoms of asthma do you experience?  cough / wheeze / shortness of breath / chest tightness

How many days per week do you experience these symptoms?  __________

How many days per week do you use a rescue inhaler (albuterol/xopenex)?  ________

How many nights per month does your asthma hinder your ability to sleep?  _________

Does your asthma interfere with your ability to do activities you would like to do?  Yes / No

What triggers your asthma? (Please circle)  exercise / cold / heat / respiratory infections / change of seasons / pollens / animals / dust / mold / strong smells (such as tobacco, perfumes, detergents, etc.)
IF YOU HAVE NASAL/EYE/EAR ALLERGY SYMPTOMS

Circle the following symptoms that affect you:
sneezing / runny nose / stuffy nose / post nasal drip / itchy nose / itchy eyes / watery eyes / puffy eyes / itchy ears / itchy throat / headache / sinus pressure / snoring

What is your worst symptom of the above? ____________________________

What make these symptoms worse? indoors / outdoors / strong smells (such as perfumes and cleaning detergents) / cats / dogs / dust / molds / feathers or birds/spring/summer/fall/winter

What is your strongest trigger? ____________________________

What medications have you tried for these symptoms?
____________________________________________________________________
____________________________________________________________________

IF YOU HAVE SINUS SYMPTOMS:

Do you struggle with frequent sinus infections? Yes / No. If yes, how many in a given year?
____________________________________________________________________

Have you ever had nasal polyps? Yes / No. Have you lost your sense of smell or taste? Yes / No.

Have you ever had sinus surgery? Yes / No. If yes, list dates: ______________________________________

IF YOU HAVE HIVES:

Have you ever had hives before in your lifetime? Yes / No

When did current episode of hives start? ____________________________

How many days per week do you have hives? ____________________________

Typically how long do individual hives last? ________________

Are the hives intensely itchy? Yes / No

When hives are gone do they leave a mark on your skin? Yes / No

Have you had any infections/illnesses in the 10 days prior to the onset of hives? Yes/No

Please list any triggers you are concerned about
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Do you take any aspirin, ibuprofen or ibuprofen-like (advil, aleve, naproxyn, etc) medications? Yes / No

If yes, list: ____________________________
Have you noticed the hives to be worse with the following? Heat / cold / exercise / scratching / stress /
shower / menses / alcohol / pressure on the skin (such as waist band and bra strap areas)
Have you had swelling? Yes / No. If so, where?

Have you had any of the following? (Please circle) throat closing / shortness of breath / change in your
voice / tongue swelling / a sensation of something stuck in your throat
Do you have an epi pen? Yes / No

OTHER ALLERGIC HISTORY:

Do you have any food allergies? Yes / No If yes, list each food and the reaction you had to it:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you had any problems after bee or wasp stings? Yes / No If yes, describe the reaction (Do not
include reactions to mosquito bites):

________________________________________________________________________

________________________________________________________________________

Do you have any drug allergies? Yes / No If yes, list each medication and describe the reaction:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you have a history of latex allergy? Yes / No. If yes, describe the reaction
Do you have a history of eczema? Yes / No
LIST OF MEDICATIONS MOST COMMONLY USED
(Medications written in red interfere with testing, others are okay)

IMPORTANT: DO NOT STOP ANY MEDICATION WITH AN * WITHOUT CONSULTING THE PRESCRIBING PHYSICIAN.

*ABILIFY (5 DAYS)
ACCOLATE
ACTIFED (3 DAYS)
ACULAR
ADVAIR
ASMANEX
AEROBID
AEROBID M
AEROCHAMBER
AFRIN
ALAVERT (5 DAYS)
ALBUTEROL
ALLEGRA (4 DAYS)
ALLEREST (3 DAYS)
ALLER-TEC (6 DAYS)
ALOCRIL OPHTHALMIC SOLUTION
ALOMIDE
ALUPENT
ALUPENT MDI
ALPRAZOLAM
AMBIEN
*AMITRIPTYLINE (5 DAYS)
AMOXICILLIN
ANTIVERT (3 DAYS)
*ARIPIPRAZOLE (5 DAYS)
ASMANEX
*ASTELIN NASAL SPRAY (5 DAYS)
ASTEPRO (5 DAYS)
ATARAX (5 DAYS)
ATIVAN
ATROVENT
AUGMENTIN
AZATADINE (2 DAYS)
AZELASTINE (5 DAYS)
AZMACORT MDI
BECLOMETHASONE DIPROPIONATE
BECLOVENT INHALER
BECONASE
BECONASE AQ
BENADRYL - (Topical, too) (3 DAYS)
BRETHINE
BROMFED (2 DAYS)
BROMPHEN (2 DAYS)
BROMPHENIRAMINE (2 DAYS)
BUDESONIDE
BUPROPION (3 DAYS)
BUSPAR
BUSPIRONE
CELEXA
CETRIZINE (5 DAYS)
CHLORDIAZEPoxide
CHLOR-TRIMETON (2 DAYS)
CHLORPHENIRAMINE (2 DAYS)
CITALOPRAM
CLARINEX (6 DAYS)
CLARITIN (4 DAYS)
CLARITIN D (4 DAYS)
CLARITIN REDI-TAB (4 DAYS)
CLEMASTINE (2 DAYS)
CLONAZEPAM
CLORAZEPATE
CONTACT (2 DAYS)
CORTICOSTEROIDS-INALED OR SHORT TERM ORAL
CROMOLYN
CYPROHEPTADINE (2 DAYS)
DALMANE
DECONAMINE (2 DAYS)
DECONSEL
DELTASONE
DEPAKOTE
*DESPRAMINE (5 DAYS)
DESYREL
DIAZEPAM
DIPHENHYDRAMINE (2 DAYS)
DIMETAPP (2 DAYS)
DIVALPROEX
DORAL
*DOXEPIN (5 DAYS)
DOXEPIN TOPICAL CREAM (12 DAYS)
DRISTAN
DRIXORAL (2 DAYS)
DURATUSS
DURAVENT
DYMISTA (4 DAYS)
EFFEXOR
LIST OF MEDICATIONS MOST COMMONLY USED
(Medications written in red interfere with testing, others are okay)

IMPORTANT: DO NOT STOP ANY MEDICATION WITH AN * WITHOUT CONSULTING THE PRESCRIBING PHYSICIAN.

*ELAVIL (5 DAYS)
*ELESTAT EYE DROPS (4 DAYS)
ELICON
ELIDEL
ENTEX LA
ENTEX PSE
EPICEN
EPICEN JR.
ESTAZOLAM
EXTENDRYL (2 DAYS)
EXTENDRYL JR. (2 DAYS)

EYE DROPS - ALL ALLERGY TYPES
3 DAYS, *EXCEPT OPTIVAR &
ELESTAT, WHICH ARE 4 DAYS

FEXOFENADINE (4 DAYS)
FLONASE
FLOVENT
FLUNISOLIDE
FLUOXETINE
FLURAZEPAM
FLUTICASONE
FLUVOXAMINE
FORADIL
GUAIFED
GUAIFENESIN
GUAIVENT
HALCION
HUMIBID
HYDROXYZINE (5 DAYS)
*IMIPRAMINE (5 DAYS)
INTAL MDI
IPRATROPIUM BROMIDE
ISOPROTERENOL
ISUPREL
KLONOPIN
LANSOPRAZOLE
LASTACRAFT EYE DROPS (2 DAYS)
LIBRITABS
LIVOSTIN (2 DAYS)
LORATADINE (5 DAYS)
LORAZEPAM

LUVOX
LUNESTA
MAXAIR AUTOHALER
MECLIZINE HCL (3 DAYS)
MEDROL-depending on dose
METAPROTERENOL
MIDAZOLAM
MIDOL (2 DAYS)
*MIRTAZAPINE (7 DAYS)
MONTELUKAST
MUCINEX
NALADACON (2 DAYS)
NAPHAON-A (3 DAYS)
NASACORT
NASACORT AQ
NASALCROM
NASAREL SOLUTION
NASONEX
NEOSYMPHINE
NEFAZODONE
NEXIUM
OMNARIS
*NORPRAVIAN (5 DAYS)
*NORTRIPTYLINE (5 DAYS)
NYQUIL (2 DAYS)
OCUHIST (3 DAYS)
OMEPRAZOLE
OMNARIS
OPCON A (3 DAYS)
OPTIMINE (2 DAYS)
OPTIVAR OPHTHALMIC SOL. (4 DAYS)
OXAZEPAM
*PAMELOR (5 DAYS)
PAMPRIN (2 DAYS)
PAROXETINE
PATADAY (3 DAYS)
PATANASE (5 DAYS)
PAXIL
PBZ (2 DAYS)
PEDIAPRED
PERIACIN (2 DAYS)
PHENERGAN (2 DAYS)
PIRBUTEROL

List of medications – rev 10/22/13
Updated 10/1/15, 6/8/17
LIST OF MEDICATIONS MOST COMMONLY USED
(Medications written in red interfere with testing, others are okay)

IMPORTANT: DO NOT STOP ANY MEDICATION WITH AN * WITHOUT CONSULTING THE PRESCRIBING PHYSICIAN.

“PM” MEDICATIONS (2 DAYS)
PREDNISONE - depending on dose
PRELONE
PREVACID
PRILOSEC
PROMETHAZINE (2 DAYS)
PROSOFT
PROTOPIC CREAM OR OINTMENT
PROVENTIL INHALER
PROVENTIL INHALER HFA
PROZAC
PULMICORT
QUAZEPAM
QUETIAPINE (SERQUEL) (6 DAYS)
QUININE
QVAR
REACTINE (5 DAYS)
*REMERON (Mirtazapine) (7 DAYS)
RESTORIL
RHINOCORT
RYNATAN (2 DAYS)
RYNATUS (2 DAYS)
SALMETEROL
SERAX
SEREVENT
*SERQUEL (QUETIAPINE) (6 DAYS)
SERTRALINE
SERZONE
*SINEQUAN (5 DAYS)
SINGULAIR
SINUTAB
SLOPHYLIN
SOMINEX (2 DAYS)
SPIRIVA
SUDAFED
TAVIST (3 DAYS)
TAVIST D (3 DAYS)
TEMARIL (2 DAYS)
TEMAZEPAM
TERBUTALINE
TESSALON PERLES
THEODUR
THEOPHYLLINE

THERAFLU (2 DAYS)
TILADE MDI
*TOFRANIL (5 DAYS)
TOPAMAX
TRANXENE
TRAZODONE
TRIAMCINOLONE
TRIAMINIC (2 DAYS)
TRIAZOLAM
TRIPELENNAMINE (2 DAYS)
TUSSIONEX (2 DAYS)
TYLENOL PM (2 DAYS)
TYLENOL SLEEPY TIME (2 DAYS)
UNIPHYL
VALIUM
VALPROATE NA/ACID
VANCENASE AQ
VANCENASE AQ DOUBLE STRENGTH
VANCENASE POCKETHALER
VANCERIL DOUBLE STRENGTH
VANCERIL
VENLAFAXINE
VENTOLIN INHALER
VERAMYST
VERSED
VISTARIL (5 DAYS)
VOLMAX
WELLBUTRIN (3 DAYS)
XANAX
XYZAL (6 DAYS)
ZAFIRLUKAST
ZANTAC
ZETONNA
ZICAM11
ZILEUTON
ZOLOFT
ZOLPIDEM
ZYFLO
ZYRTEC (6 DAYS)

List of medications – rev 10/23/13
Updated 10/1/15, 6/9/17
LIST OF MEDICATIONS MOST COMMONLY USED
(Medications written in red interfere with testing, others are okay)

IMPORTANT: DO NOT STOP ANY MEDICATION WITH AN * WITHOUT CONSULTING THE PRESCRIBING PHYSICIAN.

NOTE: ANY OVER-THE-COUNTER MEDICINE WITH THE WORD "ALLERGY" OR "PM" NOT LISTED HERE USUALLY CONTAINS ANTIHISTAMINE. (3 DAYS)
Antihistamines and certain other medications interfere with the accuracy of allergy skin testing. The following is a list of common antihistamines. In addition, many cold/sinus preparations and eye drops contain antihistamines.

Some herbs, plants and supplements (including naturopathic/homeopathic) may also decrease the accuracy of allergy skin testing, and therefore all such products should be withheld for one week prior to testing.

**Examples of Antihistamines**

- Zyrtec (Cetirizine)
- Xyzal (Levocetirizine)
- Clarinex (Desloratadine)
- Claritin/Claritin-D, Alavert (Loratadine)
- Allegra (Fexofenadine)

**Most older antihistamines:**

- Benadryl (Diphenhydramine), Actifed, Allerest, Nyquil, Chlor-Trimeton, Triaminic, Dimetapp, Drixoral, Tavist, etc.

**Medications ending in "PM" (such as Tylenol PM, Advil PM, Motrin PM)**

- Thera-flu (Pheniramine), Ny-quist

- Periactin (Cyproheptadine)
- Atarax (Hydroxyzine)
- Astelin Nasal Spray (Azelastine), Astepro, Dymista
- Patanase

**Tricyclic Antidepressants:**

- *Elavil (Amitriptyline)
- *Pamelor ((Nortriptyline)
- *Tofranil (Imipramine)
- *Sinequan (Doxepin)
- *Desipramine

- Meclizine (Antivert, Bonine, Dramamine)
- *Remeron (Mirtazapine)
- *Abilify (Aripiprazole)
- *Seroquel (Quetiapine)

- Midol
- Topical Doxepin cream
- Optivar and Elestat Ophthalmic Solution
- All other allergy eye drops (Patanol, Pataday, Bepreve, Opcon A, Naphcon-A, Zaditor)

**Do not take for this number of days before the test date:**

- 6 days
- 6 days
- 7 days
- 5 days
- 4 days
- 3 days

**IF you are experiencing hives or other allergy symptoms that will make you uncomfortable when antihistamines are withheld, DO NOT STOP your medication prior to the doctor’s office visit.**