ADVANCED ALLERGY & ASTHMA CARE
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Allergy, Asthma and Clinical Immunology

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488 Main Ave, 2nd Floor
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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 $40-$80 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.____
(As on insurance card) (As on insurance card)

❑ 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) _____
(As listed on your insurance card)

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

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**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.

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**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 <u>your</u> responsibility to ensure your authorization referral is <u>current</u> and on file in this office prior to seeing the physician for all visits, including follow-ups. There are <u>NO</u> 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

***Information 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 # _____

# ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:
## Notice of Privacy Practices Informed Consent
## Practice Financial Policies
## ADVANCED SPECIALTY CARE

**Privacy Officer:** Jennifer Retter, 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. Due to HIPAA laws, we are unable to share your medical information with anyone unless you authorize to do so.
I authorize the person(s) listed below to discuss my medical information:

_____ _____
**Name & phone number** **Relationship to Patient**

_____ _____
**Name & phone number** **Relationship to Patient**

**I authorize Advanced Specialty Care staff to leave medical information, including test results, on the following voicemail/answering machines:** ☐ **Home Phone** ☐ **Work Phone** ☐ **Cell Phone**

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

Release of Records to Electronic Portal: I understand that my signature on this form authorizes Advanced Specialty Care to send my personal medical records to my personal Electronic portal account when verbally requested. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am authorizing such information to be disclosed. This authorization is effective indefinitely unless revoked in writing. I would like the following health information to be sent to my portal account:
☐ All records Other:_____

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.
Please initial each statement on line provided:
___ 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-$125 **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. I understand that any unpaid balances 120 days or older will incur $15 per month late fee.

_____ _____
**Patient Signature** (Parent or Guardian please sign if Patient a Minor) **Relationship to Patient**

_____ _____/_____/_____
**Please Print Name** **Date**

_____ _____/_____/_____
**Patients Name (if Minor)** **Patient's date of birth**

**Allergy Intake**

Patients Name:_____

Patients Date of Birth:_____

Today's Date:_____

**Patient's Height** _____ **Weight**_____

**Please list all Medications and Dosage you are currently taking**(Including prescription, non-prescription, herbal supplements)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

**Allergies to medication: Drug name/Reaction**

_____ _____

_____ _____

_____ _____

**Latex Allergy** ☐ Yes ☐ No

**Review of systems**: Please circle Yes or No

| | | | |
|---|---|---|---|
| Fatigue | Y/N | Nausea | Y/N |
| Food Allergies | Y/N | Joint swelling | Y/N |
| Cough | Y/N | Nasal congestion | Y/N |
| Depression | Y/N | Rash | Y/N |
| Itchy Eyes | Y/N | Seasonal Allergies | Y/N |
| Headache | Y/N | | |

**Personal Medical History**: Please circle Yes or No

Asthma Y/N

Allergies Y/N If "Yes" please circle Allergen below

Food Environmental Insect Pet

High Blood Pressure Y/N

Other Y/N

List any other pertinent medical history:

1. _____

2._____

3. _____

**Pharmacy Information**

Name:_____

Location:_____

**Referring MD**:_____

**Primary Care MD**:_____

**Surgical History:** Please circle Yes or No

Tonsillectomy Y / N

Adenoidectomy Y / N

Other _____

**Family History:** Please circle Yes or No

**Asthma Y/N**

Father__ Mother__ Sister__ Brother__ Son__ Daughter__

**Eczema Y/N**

Father__ Mother__ Sister__ Brother__ Son__ Daughter__

**Hay fever Y/N**

Father__ Mother__ Sister__ Brother__ Son__ Daughter__

List any other pertinent family history:

1. _____

2. _____

3._____

**Social History:** (Smoking status for patients 13 yrs. and older)

Have you ever used tobacco Y/N

Current every day smoker ☐

Current some day smoker ☐

Smoker, current status unknown ☐

Never smoker ☐

Former smoker ☐

Unknown if ever smoked ☐

**Do you chew tobacco Y/N**

**Do you drink alcohol Y/N**

If yes: Daily__Weekly__Monthly__Yearly__

**Do you consume caffeine** Y/N

Day care? ☐ Yes ☐ No

Exposed to smokers? ☐ Yes ☐ No

**Environment at home:**

Dust mite proof covers (mattress or pillows)? ☐ Yes ☐ No

**Devices** (Choose any in the home)

Dehumidifier ☐

Air purifier ☐

Wood/pellet stove ☐

Air conditioner ☐ Yes ☐ No

Carpeting (choose one) ☐ None ☐ Wall to wall ☐ Area rugs

**Residence**

Private Home ☐

Apartment ☐

Basement ☐Yes ☐No

Do you have any pets? (Choose all that apply)

Cats ☐ Dogs ☐ Birds ☐ Other ☐

Have you seen cockroaches or ladybugs in the home?

Yes ☐ No ☐

Is there visible mold in the home? ☐ Yes ☐ No

**List family members that are patients here:**

_____ _____

_____ _____

_____ _____

_____ _____

# 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 / showers / 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
BECLOMENTHASONE DIPROPRIONATE
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
*CETIRIZINE* (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)
DECONSAL
DELTASONE
DEPAKOTE
**DESIPRAMINE* (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

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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
EPIPEN
EPIPEN 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
*LASTACAFT 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
*NALDACON* (2 DAYS)
*NAPHCON-A* (3 DAYS)
NASACORT
NASACORT AQ
NASALCROM
NASAREL SOLUTION
NASONEX
NEOSYNEPHRINE
NEFAZODONE
NEXIUM
OMNARIS
**NORPRAMIN* (5 DAYS)
**NORTRIPTYLINE* (5 DAYS)
*NYQUIL* (2 DAYS)
*OCCUHIST* (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
*PERIACTIN* (2 DAYS)
*PHENERGAN* (2 DAYS)
PIRBUTEROL

## LIST OF MEDICATIONS MOST COMMONLY USED

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**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)
PROSOM
PROTOPIC CREAM OR OINTMENT
PROVENTIL INHALER
PROVENTIL INHALER HFA
PROZAC
PULMICORT
QUAZEPAM
*QUETIAPINE* (SEROQUEL) (6 DAYS)
QUININE
QVAR
*REACTINE* (5 DAYS)
**REMERON* (MIRTAZAPINE) (7 DAYS)
RESTORIL
RHINOCORT
*RYNATAN* (2 DAYS)
*RYNATUSS* (2 DAYS)
SALMETEROL
SERAX
SEREVENT
**SEROQUEL* (QUETIAPINE) (6 DAYS)
SERTRALINE
SERZONE
**SINEQUAN* (5 DAYS)
SINGULAIR
SINUTAB
SLOPHYLLIN
*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 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)*

Advanced Allergy & Asthma Care
Jonathan Bell, MD, Richard Lee, MD
Purvi Shah, MD, Yogen Dave, MD, Neetu Godhwani, MD

| | | | |
|---|---|---|---|
| 107 Newtown Road | 901 Ethan Allen Hwy | 131 Kent Road | 488 Main Ave |
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| 203.748.7433 | 203.403.7315 | 860.354.0762 | 203.857.9216 |
| Fax 203.790.5324 | Fax 203.730.4164 | Fax 860.355.1930 | Fax 203.857.8681 |


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** | **Do not take for this number of days before the test date:** |
|---|---|
| Zyrtec (Cetirizine) | 6 days |
| Xyzal (Levocetirizine) | 6 days |
| Clarinex (Desloratidine) | 7 days |
| Claritin/Claritin-D, Alavert (Loratadine) | 5 days |
| Allegra (Fexofenadine) | 4 days |
| Most older antihistamines: Benadryl (Diphenhydramine), Actifed, Allerest, Nyquil, Chlor-Trimeton, Triaminic, Dimetapp, Drixoral, Tavist, etc. | 3 days |
| Medications ending in "PM" (such as Tylenol PM, Advil PM, Motrin PM) | 3 days |
| Thera-flu (Pheniramine), Ny-quil | 3 days |
| Periactin (Cyproheptadine) | 3 days |
| Atarax (Hydroxyzine) | 5 days |
| Astelin Nasal Spray (Azelastine), Astepro, Dymista | 5 days |
| Patanase | 4 days |
| **Tricyclic Antidepressants**: *Elavil (Amitriptyline) *Pamelor ((Nortriptyline) *Tofranil (Imipramine) *Sinequan (Doxepin) *Desipramine | *5 days |
| Meclizine (Antivert, Bonine, Dramamine) | 3 days |
| *Remeron (Mirtazapine) | *7 days |
| *Abilify (Aripiprazole) | *5 days |
| *Seroquel (Quetiapine) | *6 days |
| Midol | 2 days |
| Topical Doxepin cream | 12 days |
| Optivar and Elestat Ophthalmic Solution | 4 days |
| All other allergy eye drops (Patanol, Pataday, Bepreve, Opcon A, Naphcon-A, Zaditor) | 3 days |

*__IMPORTANT__: Do not stop any medication with a * without consulting the prescribing physician.

__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.