

Paragon Central
Office
(269) 341-4554

Practices

Adult & Pediatric
Ear, Nose & Throat
(269) 343-1296

Advanced Allergy
& Asthma Care
(269) 321-6673

Advanced Vascular
Surgery
(269) 226-5200

Bright Futures
Pediatrics
(269) 372-3700

Cardiology Care
(269) 276-0800

Kalamazoo
Gastroenterology
Hepatology
(269) 385-9900

Haller Rowe
Haviland Division
(269) 343-1684

Nephrology
Center
(269) 349-6759

Neurology of
Battle Creek
(269) 969-6177

Opus Healthcare
(269) 383-6789

Veera Patel, M.D.
(269) 273-8511

Rowe Orthopaedic
Center
(269) 353-9821

Southwest
Michigan
Dermatology
(269) 321-7546

Three Rivers
Osteoporosis
Clinic
(269) 279-9055

Welcome to our practice!

- Please complete the enclosed questionnaire and mail (included stamped envelope), fax (324-5594), or email it (questionnaire@advancedallergy.com) back to us **1 week prior to your appointment.**
- Obtain a copy of your medical record if you have been previously evaluated by an allergist.
- If indicated, skin testing can be performed on your initial visit. **For this testing to be valid, you should not take any medications containing antihistamines for a period of (7) seven days prior to the appointment.** Please refer to the list of antihistamines on the back of this page. Tricyclic antidepressants also interfere with skin testing: these include Elavil (amitriptyline), Pamelor (nortriptyline), and Doxepin (sinequan). Abruptly stopping these medications may cause side effects, so call for specific instructions if you are on a tricyclic antidepressant. **Medications that you may be taking for other medical problems such as high blood pressure, diabetes, asthma, etc. should be continued as usual.** If you are uncertain about which medications you need to stop prior to this appointment, please telephone to inquire further.
- Patients coming in for evaluation of hives (itchy, red rash) may continue to take their antihistamines.
- Your evaluation may include skin testing, breathing tests and other specialized procedures in addition to your initial consult. Due to the expense involved, and the fact that some insurance plans do not provide coverage, we strongly suggest you contact your health insurance company to verify your plan covers allergy evaluations. You will be responsible for any charges your health insurance company does not cover.
- Our policy requires all co-pays be paid at check-in on the day of service for all office visits.
- We charge a \$35 fee for missed appointments. Appointments must be cancelled with at least 24 hours notice to avoid this fee. This fee is due before the patient's next appointment or allergy injection.
- Minors (up to 18 years of age) must be accompanied by a parent or guardian.
- Most initial appointments will take up to two (2) hours.
- For consideration of our patients and staff, we request you do NOT wear perfumes, colognes, and fragrant body lotions. Some of our patients have severe adverse reactions to these scents. Thank you for your understanding
- Please feel free to call us if you have any questions regarding the above, or if we can help clarify anything else prior to your appointment. Thank you for your cooperation.

Advanced Allergy & Asthma Care

Antihistamines – drugs that block allergy skin testing:

All allergy eye drops: Such as Patanol, Zaditor, generic Ketotifen

Actifed Cold and Allergy

Alavert

Allegra

Allegra-D 12 Hour

Allegra-D 24 Hour

Astelin - **Must stop for 4 weeks prior to testing**

Astepro - **Must stop for 4 weeks prior to testing**

Atarax

Benadryl

Bromfed

Bromfed-DM

Bromfed-PD

brompheniramine

cetirizine

Clarinet

Clarinet Reditabs

Clarinet-D 12 Hour

Clarinet-D 24 Hour

Claritin

Claritin Reditab

Claritin-D 12 Hour

Claritin D 24 Hour

Chlor-Trimeton

chlorpheniramine

chlorpheniramine/pseudoephedrine

clemastine fumarate

cyprohepatadine

Deconamine SR

Dimetapp

Dimetapp Cold & Allergy Elixir

diphenhydramine

fexofenadine

hydroxyzine

Ibuprofen Cold and Allergy

loratadine

loratadine/pseudoephedrine

Motrin Cold and Allergy

Palgic

Patanase – **Must stop for 4 weeks prior to testing.**

pseudoephedrine/triprolidine

Rondec DM Drops

Rondec DM Syrup

Rondec Drops

Rondec Syrup

Semprex-D

Tavist Allergy

Tussionex PennKinetic

Tylenol Cold and Allergy

Vistaril

Xyzal

Zyrtec

This is not an all inclusive list. Please call if you have any questions.

TO BE RETURNED 1 WEEK PRIOR TO APPOINTMENT

ADVANCED ALLERGY & ASTHMA CARE

Michael Park, MD
Lucetta Lyford, PA-C

430 W Centre Ave
Portage, MI 49024

Phone: (269) 321-6673
Fax: (269) 324-5594

ALLERGY/ASTHMA QUESTIONNAIRE

Name: _____ Age: _____ Appt. Date: _____

Birthdate: _____ Occupation/PlaceOfWork: _____

Describe the problem(s) you have been experiencing: _____

Length of time you have had the problem(s): _____

If you have been away from home in the past year, were symptoms better or worse while there? (Circle)

Better

Worse

No Difference

Which season(s) bother your symptoms the most? (circle)

All the time

Spring

Summer

Fall

Winter

Change of seasons

Previously evaluated by an allergist? (circle) Yes No If yes, who and when? _____

Were skin tests performed? (circle) Yes No If yes, what were the results? _____

Have you ever received allergy shots before? (circle) Yes No If yes, when did you start and end your

treatment? _____

If yes, did you feel allergy shots were helpful? (circle) Yes No

ALLERGY HISTORY

Do you live in a (circle): House Apartment Condo Dorm Mobile Home Other _____

Age of dwelling/Year built: _____ Length of Occupancy: _____

Heating (circle): Furnace/forced air Radiant Other _____

Humidifier (circle): Central Portable None Air conditioning (circle): Central Window None

Basement (circle): Damp/Musty Dry None Bedroom floor (circle): Carpeted Wooden Tile

Mattress (circle): Conventional Water Air Other _____ **How old?** _____

Pillow (circle): Feather Foam Dacron/Polyester Other _____ **How old?** _____

Pets (circle and indicate how many): Cat _____ Dog _____ Other furry pets _____

Ever been stung by a bee wasp hornet? (circle) Yes No

Ever had poison ivy/oak/sumac (circle)? Yes No **Stuffy nose that worsens at night (circle)?** Yes No

Adverse reaction to medications (specify name/reaction): _____

Adverse reaction to foods (specify food/reaction): _____

Adverse reaction to latex or rubber: _____

Adverse reaction to previous immunizations: _____

Current medications: _____

Past and current medical problems: _____

Past surgeries: _____

SOCIAL HISTORY

Partner Status (circle): Lives alone Roommate Significant other Spouse

Smoking (circle): Current Former Never **Alcohol use (circle):** Daily Weekly Monthly Yearly Never

Children (circle): Yes No **If yes, how many boys?** _____ **girls?** _____

FAMILY HISTORY

Parents (circle): Hayfever Food allergies Asthma Eczema Other _____

Siblings (circle): Hayfever Food allergies Asthma Eczema Other _____

Children (circle): Hayfever Food allergies Asthma Eczema Other _____

REVIEW OF SYSTEMS Circle and describe any other problems not mentioned above

Eyes Muscles/bones/joints _____

Ear/Nose/Throat Skin _____

Heart Neurological _____

Lungs Psychiatric _____

Gastrointestinal Hormonal _____

Genital/bladder/kidney Blood/lymphatic _____