Patient Name: **DOB:**

ALLERGY / IMMUNOLOGY HISTORY

Appt. Date:

Primary Care Physician:_____

ALLERGY PROFILE

Rhinitis/hay fever [ ] Sinusitis [ ] Food Allergy [ ] Eczema [ ] Latex Allergy [ ]
Stinging Insect [ ] Asthma [ ] Drug Allergy [ ] Hives [ ] Swelling [ ]

Check the things that trigger or worsen any of the above:

Dust [ ] Pollens [ ] Dry or cold air [ ] Fumes or perfumes [ ] Molds [ ] Exercise [ ]
Tobacco smoke [ ] Aspirin, ibuprofen, naproxen [ ] Food (Specify):
Animals (specify): Other:

Have you experienced an allergic or other adverse reaction to a medication? yes [ ] no [ ]

If yes, please list the date(s), the medication(s), and the side effect(s).

Have you been tested for any form of allergy? No [ ] Yes [ ] skin test. Yes [ ] blood test.

If yes, when was it done and which tests were positive?

Have you been previously treated for any of the above conditions?

No [ ] Yes [ ] allergy shots. Yes [ ] medications. Specify: [ ] Other

PAST MEDICAL and SURGICAL HISTORY

Please check the medical conditions that you have had and write the date of diagnosis.

[ ] Cataracts or glaucoma
[ ] Depression
[ ] Diabetes
[ ] Heart Disease
[ ] Hepatitis or any liver disease
[ ] High blood pressure
[ ] Uterine Cancer
[ ] Cervical Cancer
[ ] Vaginal Cancer
[ ] Breast Cancer
[ ] Colon Cancer
[ ] Prostate Cancer
[ ] Peptic ulcer or acid reflux
[ ] Thyroid disease
[ ] Hypercholesterolemia
[ ] Ovarian Cancer

CURRENT MEDICATIONS

FAMILY MEDICAL HISTORY

Please write any medical condition that members of your family have had:

Father: [ ] Living [ ] Deceased Age:
Mother: [ ] Living [ ] Deceased Age:
Siblings: [ ] Living [ ] Deceased Age:

Number of brothers: **Number of sisters:** **Number of children:**

Please list any family member that has had rhinitis, asthma, or allergic dermatitis:

ENVIRONMENTAL HISTORY

Please list the cities/states where you have resided, from birth to the present (including dates):
City / State: Dates:
How old is your home?
Is your home : [ ] single family house [ ] apartment [ ] townhouse [ ] mobile home
Does your home have: [ ] radiator heating [ ] humidifier [ ] central air conditioning
[ ] window air-conditioner [ ] any damp area [ ] central / forced warm air heating
[ ] cockroaches [ ] anyone who smokes
Do you have: [ ] hardwood floors [ ] area rugs [ ] wall-to-wall carpeting [ ] stuffed toys
Do you use: [ ] foam pillows [ ] fiber-filled pillows [ ] feather pillows [ ]bed mattress
[ ] box spring [ ] water bed [ ] dust-mite proof pillow covers [ ] dust-mite proof bed covers
Do you have pets? [ ] no [ ] yes If yes, specify how many and what kind:
How long have you had them? Do they go in your bedroom? [ ]no [ ] Sometimes [ ] Often

WORK HISTORY

What is your occupation?
Does your workplace have: [ ] Central Air Conditioning [ ] Window air-conditioning units?
Are you exposed to chemicals, irritants, latex products, or animals at school or work? [ ] No [ ] Yes
If yes, specify:

PERSONAL AND SOCIAL HISTORY

Do you smoke cigarettes? [ ] No [ ] Yes
If yes, how many packs per day? **How many years?**
Do you drink alcoholic beverages? [ ] No [ ] Yes If yes, how much? How often?
Please list your hobbies:

REVIEW OF SYSTEMS

Please check all that apply to you:
Constitutional: [ ] fever or chills [ ] weight change [ ] fatigue
Eyes: [ ] itchy/watery eyes [ ] glasses or contacts
ENT: [ ] hearing loss [ ] earache [ ] runny nose [ ]stuffy nose [ ] frequent sneezing [ ] mouth ulcers [ ] hoarseness [ ] postnasal drip [ ] nosebleeds
Resp: [ ] cough [ ] breathlessness [ ] wheezing [ ] chest tightness [ ] bloody sputum [ ] abnormal x-ray
CV: [ ] chest pain [ ] palpitations [ ] heart murmur [ ] abnormal heart rhythm
GI: [ ] heartburn [ ] abdominal pain [ ] jaundice [ ] diarrhea [ ] constipation [ ] bloody stools
GU: [ ] dysuria [ ] frequency of urination [ ] urinary incontinence
Heme: [ ] anemia [ ] easy bruising [ ] abnormal bleeding
Skin: [ ] rash [ ] itching [ ] frequent hives
Musculoskeletal: [ ] joint pain [ ] joint swelling [ ] joint stiffness [ ] muscle pain
Neuro: [ ] seizures [ ] weakness [ ] numbness
Psych: [ ] depression [ ] difficulty sleeping
ADDITIONAL INFORMATION:

Physician's Signature _____

Victory Medical
ALLERGY

Patient Name:
Date of Birth:
Date of Visit:

Informed Consent
Allergy Skin Testing Procedure

Following a historical review of your symptoms and an appropriate physical assessment, skin testing will be performed in the presence of your physician. This procedure is of value to document the presence of specific allergic sensitivity. Such skin testing may utilize extracts of inhalants (pollen, dust, feather, dander, etc.), food, hymenoptera venom (honey bee, vespid, wasp, hornet). Skin testing is a rapid clinically relevant test currently available for allergy assessment. A small percentage of patients may experience reactions such as hives, pruritus, upper respiratory symptoms or wheezing, gastrointestinal symptoms, anaphylaxis with hypertension, and/or cardio-respiratory arrest. The only alternative methods are blood tests, known as RAST. RAST tests are not 100% conclusive.

The type and manner of testing to be performed include:

1. Prick Test: A drop of allergenic extract is placed on either the forearm or the back, and a needle is used to prick the skin through the drop of extract.

If you do not respond to the environmental allergens on the prick level, the next level is known as the intradermal test.

2. Intradermal Test: The allergenic extract is injected under the skin of the fore-arm using a small needle.

Upon completion of the testing, your physician will evaluate you, and a diagnosis will be determined. Immunotherapy (injection therapy) may be instituted depending on the correlation of the skin testing results with your symptoms.

Acknowledgement and Consent

My doctor has discussed with me the need for the tests and procedures described above, the available alternative, and the implications for my care and condition if the tests are not performed. My signature below is acknowledgement that, having read this form, I understand and agree to its content, that the proposed procedure (s) and potential risks involved have been satisfactorily explained to me, and I have sufficient information to give this informed consent. I voluntarily give my authorization and consent to Dr. Gary Albertson, D.O. and qualified M.A., as he/she may designate to perform these tests and procedures and render any further care which may be necessary in the course of my care.

Signature:_____ Date:_____

Witness:_____

Victory Medical
ALLERGY

Consent for Administration of Allergy Injections

PLEASE READ AND BE CERTAIN THAT YOU UNDERSTAND THE FOLLOWING INFORMATION PRIOR TO SIGNING THIS CONSENT FOR ALLERGY TREATMENT

PURPOSE

The purpose of immunotherapy (allergy injections) is to decrease your sensitivity to allergy-causing substances, so that exposure to the offending allergens (pollen, mold, mites, insects, etc.) will result in fewer and less-severe symptoms. This does not mean that immunotherapy is a substitute for avoidance of known allergens or for allergy medications.

INDICATIONS

To qualify for immunotherapy, you must be allergic to one or more environmental substances that you cannot avoid. You may have hay fever or asthma that occurs upon exposure to a suspected allergen, or you may have a history of severe reaction to an insect sting. Because of risks associated with immunotherapy, avoidance measures and medical management usually should be attempted first.

EFFICACY

Improvement in your symptoms will not be immediate. It usually requires *three to six months* before any relief of allergy symptoms is noted, and it may take 12 to 24 months for full benefits to be evident. Usually 85% to 90% of allergic patients on immunotherapy note significant improvement of their symptoms. This means that symptoms are reduced, although not always eliminated.

PROCEDURE

Allergy injections usually are begun at a very low dose. This dosage is gradually increased on a regular (usually weekly) basis until a therapeutic dose (often called the "maintenance dose" is reached). Maintenance doses will differ from person to person. Injections typically are given once or twice a week while the allergen dose is being increased. This frequency reduces the chances of a reaction and permits the maintenance dose to be reached within a reasonable amount of time. After the maintenance dose is determined, the injections may be given every one to four weeks.

DURATION OF TREATMENT

It usually takes three to six months to reach a maintenance dose. The time may be longer if there are allergy shot reactions or if the injections are not received on a regular basis. For this reason, it is important that the recommended schedule of injections be followed. If you know that you cannot receive regular injections, immunotherapy should not be started. Allergy injections may be discontinued at the discretion of your physician ***if injections are frequently missed,*** as there is an increased risk of reactions under these circumstances. Most immunotherapy patients continue treatment for three to five years, after which the need for continuation is *reassessed.*

ADVERSE REACTIONS

Allergy injections are associated with some widely recognized risks. The risk is present because a substance to which you are known to be allergic is being injected into you. Some adverse reactions to allergy injections are potentially life-threatening and may require immediate medical attention. Here are brief descriptions of the kinds of possible reactions listed in order of increasing severity:

A. Local Reactions

Local reactions are common and usually are restricted to a small area around the site of the injections.

However, they may involve the entire upper arm, with varying degrees of redness, swelling, pain and itching. These reactions are more likely to occur as you reach the higher concentrations and higher volume injections. The reactions may occur several hours after the injection. You should notify the nurse if your local reaction exceeds two inches in diameter or lasts until the following day.

B. Generalized Reactions

Generalized reactions occur rarely, but are the most important because of the potential danger of progression to low blood pressure and death if not treated. All generalized reactions require immediate evaluation and medical intervention. Generalized reactions may be of one or more types:

1. **Urticarial reactions (hives)** include rash, swelling and itch of more than one part of the body. There may be mild-to-moderate discomfort, primarily from the itching. This uncommon reaction may occur within minutes to hours after an injection.
2. **Angioedema** is swelling of any part of the body, inside or out, such as the ears, tongue, lips, throat, intestine, hands or feet, alone or in any combination. This is occasionally may be accompanied by asthma or difficulty with breathing and may progress to the most severe reaction, anaphylactic shock. In the absence of shock, this principal danger lies in suffocation resulting from swelling of the airway. Angioedema may occur within minutes after the injection and requires immediate medical attention

3. **Anaphylactic shock** is acute asthma, vascular collapse (low blood pressure), unconsciousness and potentially death. This reaction usually occurs within minutes of the injection and is extremely rare.

The above generalized reactions are unpredictable and may occur with the first injection or after a long series of injections, with no previous warning. All generalized reactions require immediate evaluation and medical intervention. If a localized or generalized reaction occurs, the immunotherapy dosage will be adjusted. Appropriate advice and treatment will always be available from our office staff at the time of any adverse reaction.

OBSERVATION PERIOD FOLLOWING INECTIONS

All patients receiving immunotherapy injections should wait in the physician's office **for 30 minutes after each injection**. If you have a reaction, you may be advised to remain longer for medical observation and treatment.
If a generalized reaction occurs after you have left the physician's office, you should **immediately** return to the office or go to the nearest emergency medical facility. If you cannot wait the 30 minutes after your injection, you should not receive an immunotherapy injection.

There are several allergy shot-related deaths each year in the United States. Most generalized reactions are non life-threatening if treated promptly. You should wait in your doctor's office for the suggested observation time to be close to emergency treatment if needed. If you do not remain in the office for the designated time, your doctor may recommend that you discontinue immunotherapy.

Under no circumstances will injections be given without the immediate availability of emergency medical treatment. If the prescribed injections are to be given elsewhere, you must provide the name and address of the physician who will assume the responsibility for your injections. You will be asked to complete the ***"Request for Administration of Allergy Injections at an Outside Medical Facility."***

PREGNANCY

Females of child-bearing potential: If you become pregnant while on immunotherapy, notify the office staff immediately so that the physician can determine an appropriate dosage schedule for the injections during pregnancy based on the recommendations of OB/GYN. Immunotherapy doses will not be advanced during pregnancy, but may be maintained at a constant level.

NEW MEDICATIONS

Please notify the office staff if you start any new prescription medication, particularly medication for high blood pressure, migraine headaches or glaucoma. "Beta blocker" medications, often prescribed for heart diseases, are usually not allowed while on immunotherapy. Your injections may have to be discontinued if you take a beta blocker. Your physician will have to evaluate the risk/benefit in these circumstances.

If you have any questions concerning anything in this consent for immunotherapy, please direct the questions to the nurses or to the physician. If you wish to begin immunotherapy, please sign the ***Authorization for Treatment*** (below).

CONSENT FOR IMMUNOTHERAPY (ALLERGY INJECTIONS)
AUTHORIZATION FOR TREATMENT

I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of immunotherapy, and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me from adverse reactions to immunotherapy. I do hereby give consent for the patient designated below to be given immunotherapy (allergy injections) over an extended period of time and at specified intervals, as prescribed. I hereby give authorization and consent for treatment by Dr. Gary Albertson, D.O., and staff, including authorization and consent for treatment of any reactions that may occur as a result of an immunotherapy injection.

_____
Printed Name of Immunotherapy Patient

_____
Patient Signature (or Legal Guardian)

_____ _____
Witness Date

I certify that I have counseled this patient and/or authorized legal guardian concerning the information in this ***Consent for Administration of Allergy Injections*** and that it appears to me that the signee understands the nature, risks and benefits of the proposed treatment plan.

_____,D.O.. _____
Date Signed