ROCHESTER
REGIONAL HEALTH | **Rochester Regional Health**

----- **Patient Demographics** -----

Permission to Communicate

Is there anyone you would allow us to discuss PHI (Protected Health Information) with?

☐ No - Do not discuss PHI with anybody

☐ Yes - Please add/edit persons by writing their name, phone number and any comments, and indicate their relationship to you, using the appropriate 'relation' check box(es).

Name: ______________________________ Phone: ______________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Name: ______________________________ Phone: ______________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Name: ______________________________ Phone: ______________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Name: ______________________________ Phone: ______________
Relationship: ☐ Parent / Legal Guardian ☐ Spouse ☐ Grandparent ☐ Sibling ☐ Other relative ☐ Other Caregiver ☐ Other

Comment: ______________________________

This form will cover all RRH locations, with the exception of OB-Gyn, Psychiatry, Pediatrics and Genetics, at which you may be asked to fill out an additional form specific to that practice setting.

Permissions:
☐ Appointment Information.
☐ Billing Inquiries/Statements.
☐ Detailed Message.
☐ Diagnosis and Lab Results.

I have reviewed the above information and agree that it is accurate.

Patient Name ______________________________ Patient Date of Birth ______________

Patient's Signature ______________________________ Date ______________

Personal Representative's Name (Please Print) and Sign ______________________________ Date ______________

RRH Representative ______________________________ Date ______________ Time ______________

ROCHESTER REGIONAL HEALTH

Allergy/Immunology/Rheumatology

----- Patient Demographics -----

NEW PATIENT QUESTIONNAIRE

Reason you are here today for evaluation:

Who referred you to our practice?

Please list any chronic medical conditions or health problems you have had (include acid reflux, high blood pressure, diabetes, cancer, etc.):

Please list any past surgeries you have had with the approximate date: (include tonsils/adenoid removal, sinus surgery, gallbladder removal, etc.):

Please list all medications you are taking (include over the counter medications, vitamins, birth control pills):
☐ None ☐ Complete separate sheet for medications

Have you ever had a suspected allergic reaction to any MEDICATIONS in the past? If so, please list below:

Have you ever had a suspected allergic reaction to any FOODS in the past? If so, please list below:

Please mark an "X" where appropriate:

Family History	Environmental allergies	Food allergies	Asthma	Eczema/itchy skin	Hives or swelling of skin	OTHER (please list high blood pressure, diabetes, etc.)
Mother						
Father						
Brother(s)						
Sister(s)						

Social History:

Do you currently smoke? ☐ Yes ☐ No If yes, how many years:	Any indoor pets? ☐ Yes ☐ No If yes, please list type of pets and how many:
Are you currently employed/in school? ☐ Yes ☐ No Occupation/School:	Have you seen an allergist before? ☐ Yes ☐ No If yes, who did you see and when?

Questions for MD:

The information that I have written/filled in above is true to my knowledge.

Patient Signature (or Responsible Party) **Date**

Downtime version - please follow downtime procedure.
Required identifiers (Name & DOB) must be on every page (both sides if two-sided form).
Use demographic labels or legibly hand-write the demographic information.

ROCHESTER REGIONAL HEALTH | ALLERGY, IMMUNOLOGY & RHEUMATOLOGY

----- Patient Demographics -----

SKIN TEST INFORMATION

PATIENT INFORMATION

Name:_____ Date:_____

DOB:_____

SKIN TEST APPOINTMENT Day:_____ Date:_____ Time:_____

ALLERGY SKIN TESTING

Skin testing is a method for finding out what may be causing your allergy symptoms. This is done by a nurse and will take approximately 30-60 minutes. This will allow the physician to decide on the best form of treatment for your condition. Skin testing consists of two parts:

1. Drops of allergy extracts will be placed on your back using a small testing probe with a lancet type device. This is not painful. A positive reaction after 15 minutes will resemble a small mosquito bite and may cause some itching.
2. The second part consists of injecting small amounts of the allergen extract under the skin of the upper arm with a fine needle. This causes a quick, pinching feeling. A positive reaction after 15 minutes will resemble a small mosquito bite and may cause some itching. Of note, this type of testing is sometimes not required, especially in children.

IMPORTANT SKIN TESTING NOTES

1. **Some medications interfere with skin testing. A list of medication to avoid is attached. If you have questions about medications, please call the office and speak to a nurse. *Your test will need to be rescheduled if you take any of these medications.***
2. The physician will make treatment recommendations based on the results of testing.
3. The time set aside for your skin test is exclusively yours. If for any reason you need to change your appointment, please notify us as soon as possible.
4. Children under 18 years of age who are being tested must be accompanied by a parent or guardian.
5. ***ALL ASTHMA INHALERS CAN BE CONTINUED PRIOR TO SKIN TESTING***
6. Check with your physician if you are taking Xolair.

***** PLEASE CHECK WITH YOUR PRIMARY DOCTOR CONCERNING THE SAFETY OF DISCONTINUING THESE MEDICATIONS *****

The following ***should NOT be taken for 7 DAYS prior*** to skin testing.

If you are not able to stop these medications for 7 days, keep your appointment with the allergist and you can discuss testing options.

AMITRIPTYLINE (Elavil, Endep, Etafron, Limbitrol, Triavil)	IMIPRAMINE (Tofranil, Imavate, SK-Pramine)	RISPERDAL (Risperidone)
DESIPRAMINE (Norpramin, Pertofrane)	NORTRIPTYLINE (Pamelor)	SEROQUEL (Quetiapine)
DOXEPIN (Sinequan, Adapin)	REMERON (Mirtazapine)	TRAZODONE (Desyrel)
GEODON (Ziprasidone)	Rexulti (Brexpi Prazol)	ZYPREXA (Olanzapine)

THE FOLLOWING MEDICATIONS *ARE SAFE* TO BE TAKEN PRIOR TO SKIN TESTING

Cortisone preparations such as Prednisone, Medrol, Albuterol, Montelukast, Accolate and Antibiotics

See Reverse Side

URGENT! DRUGS *NOT* TO BE TAKEN PRIOR TO SKIN TESTING

This is an incomplete list. Please call the office before taking ANY other prescription or over-the-counter medications, including those prescribed by another doctor. Please follow the WAITING PERIOD below by not taking these medications for the number of days indicated prior to your visit.

Name Brand	Generic	Indication	Waiting Period
ACTIFED	TRIPRODLIDINE	COLD/FLU	3 DAYS
ALAVERT	LORATADINE	ALLERGY	7 DAYS
ALKA-SELTZER PLUS		COLD/FLU	3 DAYS
ALLEGRA / ALLEGRA D	FEXOFENADINE	ALLERGY	5 DAYS
ASTELIN / ASTEPRO	AZELASTINE	NASAL SPRAY	7 DAYS
ATARAX	HYDROXYZINE	ALLERGY / ANXIETY	7 DAYS
AXID	NIZATIDINE	STOMACH	3 DAYS
BENADRYL / NYTOL / SOMINEX	DIPHENHYDRAMINE	ALLERGY	3 DAYS
CHLORTRIMETON / TRIAMINIC /	CHLORPHENIRAMINE	ALLERGY	3 DAYS
CLARINEX	DESLORATIDINE	ALLERGY	7 DAYS
CLARITIN / COUNTER-ACT	LORATADINE	ALLERGY	7 DAYS
CONTAC / SUDAFED / SINUTAB	PSEUDOPHEDRINE	COLD / FLU / ALLERGY	3 DAYS
DIMETAPP	BROMPHENIRAMINE	COUGH	3 DAYS
DRAMAMINE (and all other drugs for dizziness or motion sickness)	DIMENHYDRINATE	VERTIGO/MOTION SICKNESS	3 DAYS
DRIXORAL	DEXBROMPHENIRAMINE	ALLERGY	3 DAYS
FLEXERIL	CYCLOBENZAPRINE	PAIN	7 DAYS
MIDOL / PAMPRIN / PREMSYN	PYRILAMINE	MENSTRUAL SYMPTOMS	3 DAYS
NORFLEX	ORPHENADRINE	MUSCLE RELAXANT	7 DAYS
NYQUIL (and other multi-symptom cold medicines)		COLD/FLU	3 DAYS
OPCON-A	NAPHAZOLINE	ALLERGY EYE DROPS	3 DAYS
OPTIVAR	AZELASTINE	ALLERGY EYE DROPS	3 DAYS
PATADAY / PATANOL	OLOPATADINE	ALLERGY EYE DROPS	3 DAYS
PATANASE	OLOPATADINE	NASAL SPRAY	7 DAYS
PEDIACARE / BENYLIN	DEXTROMETHORPHAN	COLD / COUGH	3 DAYS
PEPCID / PEPCID AC	FAMOTIDINE	STOMACH	3 DAYS
PERIACTIN / PERITOL	CYPROHEPTADINE	ALLERGY	7 DAYS
TAGAMET / TAGAMET HB	CIMETIDINE	STOMACH	3 DAYS
TAVIST	CLEMASTINE	ALLERGY	3 DAYS
TOPICAL CREAMS	PROMOXINE	ITCHING	7 DAYS
TYLENOL PM / ADVIL PM (and other similar medicines)	DIPHENHYDRAMINE	PAIN / ALLERGY	3 DAYS
VASOCON-A	ANTAZOLINE/NAPHAZOL	ALLERGY EYE DROPS	3 DAYS
VISTARIL	HYDROXYZINE	ALLERGY / ANXIETY	7 DAYS
XYZAL	LEVOCITERIZINE	ALLERGY	7 DAYS
ZANTAC	RANITIDINE	STOMACH	3 DAYS
ZATIDOR	KETOTIFEN FUMARATE	ALLERGY EYE DROPS	3 DAYS
ZYRTEC	CETRIZINE	ALLERGY	7 DAYS