

## MEDICATIONS & ALLERGY TESTS

### Medications which Interfere with Allergy Skin Tests

Certain over-the-counter and prescriptions medications contain ingredients which affect allergy skin tests. Check labels of all medications you are using (including eye drops and nasal sprays) to determine whether your medication contains any ingredient listed below. For questions regarding ingredients, contact your pharmacist. The medications listed must be held for at least the amount of time indicated prior to allergy skin tests.

	<b>MINIMUM TIME HELD PRIOR TO APPOINTMENT</b>
<b>EYE DROPS</b>	
Pataday, Patanol, Optivar, Zaditor, Alaway, Elestat, olopatadine, azelastine, ketotifen, epinastine	7 days
Pheniramine (e.g. Visine Allergy Eye drops)	48 hours
<b>NASAL SPRAYS</b>	
Pataday, Patanol, Optivar, Zaditor, Alaway, Elestat, Astelin, Astepro, azelastine, Patanase, olopatidine	7 days
<b>ORAL MEDICATIONS</b>	
Benadryl, diphenhydramine (allergy medications and sleep aids)	48 hours
doxylamine, pyrilamine, pheniramine (in allergy, cold, and sinus meds)	48 hours
Phenergan, promethazine (in prescription cough syrups and anti-nausea)	48 hours
Periactin, cyproheptadine (appetite stimulant and other uses)	48 hours
meclizine, dimenhydrinate, Antivert, Bonine, Dramamine (motion sickness)	48 hours
ranitidine, famotidine, nizatidine (indigestion, heartburn medications)	48 hours
Chlor-Trimeton, Tussionex Cough Syrup, chlorpheniramine (in allergy, cold, and sinus meds)	5 days
Zyrtec, Xyzal, Atarax, Vistaril, cetirizine, levocetirizine, hydroxyzine (allergy & itch)	5 days
Claritin, Alavert, loratidine (in non-prescription allergy medications)	7 days
fexofenadine, Allegra, Clarinex, desloratidine, brompheniramine, Brovex, and Lodrane	7 days
Remeron, mirtazapine (treatment of pain, depression, appetite stimulant)	7 days
<b>TRICYCLICS</b> (headach, neuralgia, other chronically painful conditions)	
amitriptyline, Elavil, imipramine, Tofranil	7 days
doxepin, Sinequan, Pamelor, nortriptyline	10 days

Psychotropic — Zyprexa, chlorpromazine, Thorazine, perphenazine, Clozaril, clozapine may affect allergy tests. These medications should **NOT** be modified except by instruction of the prescribing physician. Please notify the clinic in advance of your appointment if you are taking any of these medications.

If you are taking medication with antihistamine effects which cannot be stopped for any reason, continue taking the medication and let the clinic know in advance of your initial visit. In most cases, alternative medications which will not affect skin tests can be provided at the time of your initial visit with skin testing postponed for a subsequent appointment.

## Medications that do **NOT** Interfere with Allergy Skin Tests

The following medications do not interfere with allergy skin tests and may be continued.

### **EYE DROPS**

---

Lotemax

### **NASAL SPRAYS**

---

fluticasone, Flonase, Veramyst, Nasonex, Nasocort Aq., Rhinocort, and Omnaris

### **ORAL MEDICATIONS**

---

pseudoephedrine, phenylephrine decongestants

Singulair (allergy)

prednisone, prednisolone, methylprednisolone, Medrol

Mucinex, guaifenesin

Delsym, dextromethorphan (cough medications)

All asthma inhalers

Protonix, Prevacid, Nexium, Aciphex (prescription stomach acid reducers)

omeprazole, Prilosec (non-prescription stomach acid reducers)

Other medications without effect on allergy skin testing include antibiotics, high blood pressure, arthritis, cholesterol, diabetes, cardiac, anticonvulsant, thyroid medications, most insomnia, anxiety, depression medications (including Ambien, Lunesta, Xanax, Ativan, Valium, Prozac, Effexor, Zoloft, bupropion, Wellbutrin, fluoxetine, sertraline, Celexa, Lexapro), and eye drops used for glaucoma.

If you have any questions about the possible effect of other medications you might be taking, do not hesitate to contact the clinic.

## Allergy Questionnaire

Please bring this completed questionnaire with you to your appointment.

### FOR OFFICE USE ONLY

Appointment Date: \_\_\_\_\_ Patient: \_\_\_\_\_  
Account #: \_\_\_\_\_ DOB: \_\_\_\_\_

1. Do you have any of the following symptoms? Circle Yes or No.

Fatigue	YES	NO	Mouth breathing	YES	NO
Irritability	YES	NO	Itchy nose/eyes	YES	NO
Abdominal pain	YES	NO	Runny nose	YES	NO
Diarrhea/Cramps	YES	NO	Obstructed nose	YES	NO
Pale face	YES	NO	Sneezing	YES	NO
Skin rash	YES	NO	Watery eyes	YES	NO
Stuffy ears	YES	NO	Red eyes	YES	NO
Circles under eyes	YES	NO	Wheezing	YES	NO

Which one of the above symptoms bothers you most? \_\_\_\_\_  
\_\_\_\_\_

2. Have you had any reaction to: (if Yes, please explain symptoms)

Animals	YES	NO	_____
Pollens	YES	NO	_____
Dust	YES	NO	_____
Smoke	YES	NO	_____
Exhaust	YES	NO	_____
Perfumes	YES	NO	_____
Alcohol	YES	NO	_____
Foods	YES	NO	_____
Feathers	YES	NO	_____
Chemicals	YES	NO	_____
Medication	YES	NO	_____
Insects	YES	NO	_____

3. When are symptoms worse? (Seasons, time of day, special places, locations, etc.)

\_\_\_\_\_

4. Do you have any relatives with allergy problems? Please explain.

\_\_\_\_\_

5. Do you have any of the following in your home or work place?

Old Mattress	YES	NO	Feather pillow	YES	NO
Down Comforter	YES	NO	Animal furs	YES	NO
Hot water heater	YES	NO	Open crawl spaces	YES	NO
Electric heat	YES	NO	Wall to wall carpet	YES	NO
Forced air	YES	NO	Wood heat	YES	NO
Pets	YES	NO	What kinds?	_____	

6. Have you ever had any previous allergy testing or treatment? Describe.

\_\_\_\_\_

7. Do you have other symptoms, not listed above?

\_\_\_\_\_