BIO ALLERGENIX

Thank you for your interest in Bio Allergenix!

The day of your appointment:

*Our testing is performed on a strict time schedule, so **please be on time**. The following reminders will help make your visit go more smoothly.*

- Do not take any supplements or unnecessary medications for four hours before your appointment.
- Please drink a lot of water for 24 hours before your visit. We will need you to be well hydrated.
- Do not wear pantyhose or clothes with very tight sleeves, as they will interfere with the testing procedures.
- Do not wear any jewelry. You may wear your wedding ring.
- Please do not take any aspirin or pain medication for 12 hours before being tested, if possible.
- Do not consume alcohol for 12 hours before your appointment.
- Please do not wear perfume, strong smelling deodorant, fragrances, essential oils, **hand lotion**, aftershave or cologne on the day of your visit. **(before *or* after)**.
- Please schedule appointment so that you are not being tested during the first three days of you menstrual cycle.
- If you need to reschedule your appointment, please do so no later than noon two (2) business days prior to your appointment to avoid a cancellation fee.
- We may be performing several tests during your visit. You will be filling out an extensive questionnaire and speaking with the doctor. Expect to be here at least one hour.
- At the end of your visit you may be given some instructions and a list of foods to avoid for 24 hours.
- Please eat before your appointment. You may be asked to avoid food for a short time after your visit or to eat very little. Do not come to the office hungry.

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If you receive a treatment on the first visit:

- You may not shop for eight hours after the visit. So please shop in advance of your visit.
- You may not go to a restaurant for eight hours. (for *any* reason)
- You may not visit a hair salon, barber shop, or nail salon for twelve hours after being treated.
- You must avoid all chemicals for twelve hours, so please refuel your automobile before your visit.
- You may not bathe or shower for eight hours after treatment, so please shower before your visit.
- Do not chew gum, use breath mints, drink anything except water or eat anything after arriving for your visit.
- Not permitted for twelve hours after treatment: *Massage, Acupuncture, Vigorous Exercise, Hot Tub, Sauna, Steam Room or Swimming.*
- You may not consume alcohol for twelve hours after treatment.
- Do not eat a large meal after treatment.
- You may be given a list of additional things to avoid for twenty four hours after treatment.

The restrictions above are designed for the worst case scenario.

We have designed these suggestions based on years of practical experience. You may be able to break some or all of the rules and do just fine, or you may bend one rule and have to repeat the visit. You will have the best chance for success if you follow all the suggestions. The restrictions are to be followed for 24 hours, a small price to pay for a long term benefit.

ALLERGY QUESTIONAIRE

Patient Name: _____ **Date:** _____
Address: _____ **Date of Birth:** _____
City, State, Zip: _____ **Home#:** _____
Gender (circle one): **MALE FEMALE** **Work#:** _____
Primary Care Physician: _____ Referring **Physician:** _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single "healthy" diet that will work for everyone.*
- *Just because food is considered "healthy", does not mean it is "healthy" for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin**, or **inhale**.*
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: _____
_____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

Infant (Age 0 -2) Child (Age 3 – 5)
Child (Age 6 – 12) Adolescent (Age 13 – 18)
Adult (Age 19 – 25) Adult (Age 26 – 40)
Adult (Age 40)

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY

Yes, and allergy shots helped. Yes, but allergy shots did not help
Yes, and medication helped Yes, but medication did not help
None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

Mother Father
Brother/Sister Grandparents
Son/Daughter Spouse
None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

Constant, Chronic with Little Change
Present Most of the Time
Present Part of the Time
Present Rarely
No Interference with Normal Life
Slight Interference with Normal Life
Considerable Interference with Normal Life
Prevents Some Normal Activities

SYMPTOMS ARE WORSE

Outdoors, and better indoors
At nighttime
In the bedroom or when in bed
During windy weather
During wet or damp weather
When the weather changes
During known pollen seasons
In certain rooms or buildings
When exposed to tobacco smoke
With yard work, cut grass, leaves, hay or barns
When sweeping or dusting the house
In areas with mold or mildew
In air conditioning
In fields or in the country
Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

After shower or bath
In air conditioning
Indoors
During or after physical activity
After taking antihistamines
With allergy shots

What makes you feel better? _____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

Dogs
Cats
Horses or Cattle
Rodents (mice, guinea pigs, etc.)
Rabbits
Birds or Feathers
Bees
Other_____
None

FOOD RELATED SYMPTOMS

Symptoms flare 5 – 60 minutes after meals
Some foods are craved or addictive
The smell or odor of some foods increases symptoms
Some foods cause nasal symptoms
Some foods cause swelling of mouth or tongue
Some foods cause rashes or hives
Some foods cause upset stomach or vomiting
Some foods cause diarrhea
Symptoms occur with restaurant salad bars or Asian foods
Some foods cause headaches
Symptoms occur with any regularly eaten food
Some foods cause asthma
Preservatives, additives or food coloring increase symptoms
No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE.

Eggs
Milk
Beef
Corn
Wheat
Soybean
Peanut
Pork
Fish
Shellfish
Orange or other citrus
Potato
Tomato
Yeast

Chocolate Coffee or Tea
Other: _____

CHEMICALS THAT CAUSE SYMPTOMS

Insecticides & Pesticides
Perfumes & Cosmetics
Stove or Furnace Emissions
Chemicals in the workplace
Newsprint
None
Paints & Household Cleaners
Gasoline or Automobiles Exhaust
The Smell of New Fabrics or Fabric Store
Laundry Detergent
Other: _____

WHEN ARE YOUR SYMPTOMS WORSE: Year Round?

January	February	March
April	May	June
July	August	September
October	November	December

MEDICATIONS:

Do you take any of the following medications on a regular basis?

Antihistamines
(Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc.)
Bronchodilators
(Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc.)
Steroid Inhalers
(Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc.)
Nasal Steroids
(Beconase, Flonase, Nasacort, Rhinocort, etc.)
Medications that affect the immune system
(Prednisone, Imuran, Methotrexate, Cellcept, Cytoxan, Cyclosporine, Tacrolimus, etc.)
Chemotherapy

Please list any medications that you are currently taking: _____
_____

SMOKING:

Do you presently smoke? Yes No If yes, average number of cigarettes per day: _____
If yes, at what age did you start? _____
Does anyone smoke in your home? Yes No

PREVIOUS ALLERGY EVALUTION:

Have you ever seen an allergist? Yes No
Have you had allergy skin testing? Yes No
Did you have any positive reactions? Yes No If yes, please list positive allergens (include any medications):
_____
Have you ever received allergy injections? Yes No

WORK ENVIRONMENT:

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? Yes No: If yes, briefly explain: _____

_____

_____

Are your symptoms worse while at work? Yes No If yes, briefly explain: _____

_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

_____

_____

_____

ANYTHING YOU WOULD LIKE TO ASK? _____

_____