PATIENT INFORMATION

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<td>First Name</td>
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<td>Occupation</td>
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<td>Ins. Company</td>
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</table>

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE?  YES [ ]  NO [ ]

IF THE ANSWER IS YES, PLEASE GIVE THE PATIENT'S NAME:  

RESPONSIBLE PARTY INFORMATION

If the patient is a minor, the parent with whom the child resides is the responsible party:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Responsible Party</td>
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<td>Address</td>
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<td>Ins. Company</td>
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SPouse OR OTHER PARENT INFORMATION

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<th>Field</th>
<th>Information</th>
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<td>Name</td>
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<td>Occupation</td>
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<td>Employer</td>
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<td>Telephone</td>
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INSURED INFORMATION

Patient’s Relationship to Insured (Spouse, Child, Dependent, Other):  

If ‘Other’ Please Specify:  

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<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Name of Insured</td>
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<td>DOB</td>
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<tr>
<td>Address</td>
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<td>State</td>
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<td>Zip</td>
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</table>
NEW PATIENT INFORMATION

Date of Visit: ______________ Date of Birth: ______________

Name: ______________________ Age: __________
Phone: Home ( ) ______________ Phone: Work ( ) ______________

Primary Care Doctor: ______________ Referring Doctor: ______________
Pharmacy: ______________ Phone #: ______________

Briefly describe your main reason for today’s visit: ____________________________

How long have you had these problems? ____________________________
How frequently do you experience these problems? ____________________________

I. ALLERGY HISTORY

Nasal Symptoms/Causes
1. I have the following symptoms (circle all that apply and star the most troublesome):

   - nasal congestion
   - fatigue/irritability
   - post nasal drip
   - runny nose
   - sneezing
   - nasal polyps

   - nasal itch/rub
   - red eyes
   - itchy eyes
   - sinus infections
   - discolored drainage

   - bad breath
   - snoring
   - mouth breathing
   - nosebleeds
   - loss of taste/smell
   - headaches

2. Circle all symptom triggers (circle all that apply and star the most troublesome):

   - dust
   - pollen
   - springtime pollen
   - cut grass/rake leaves
   - dog
   - cat
   - other animals
   - feathers

   - mold/mildew/
   - mustiness/dampness
   - indoors
   - outdoors
   - smoke

   - time of day - am/pm
   - home
   - workplace
   - food
   - weather changes
   - temperature changes

Do your symptoms occur year-round or are they seasonal? Circle one or both. If seasonal, list months symptoms occur: ____________________________

3. Have you had sinus x-rays or CT Scan? Yes No

II. RESPIRATORY HISTORY

1. Circle any applicable symptoms.

   - cough
   - tightness
   - cough from post nasal drip
   - symptoms with exercise
   - wheeze
   - shortness of breath

   If you circled any of the above symptoms, complete questions 2-7

2. Do you wake up at night because of chest symptoms? Yes No
   times per week/month ______________

3. Did you have problems with your breathing at birth? Yes No
   If yes, explain: ____________________________

4. Breathing problem is triggered by:

   - pollen
   - mold
   - foods
   - exercise
   - heartburn
   - pets
   - weather change/rain

   - colds
   - sinus infections
   - cold weather
   - other

5. Circle any events attributable to your asthma:

   - ER visits
   - Hospitalization
   - Intubation
   - ICU admission
   - Pneumonia

6. Have you been on steroids or received a steroid shot for your asthma? Yes No
   If yes, how many times in the past 12 months? ______________

7. Have you had a chest x-ray? Yes No
   Last x-ray: ______________
III. MEDICATIONS
I take the following medications (include inhalers and nasal sprays):

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency used</th>
</tr>
</thead>
<tbody>
<tr>
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<td>daily/often/rarely</td>
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Other medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency used</th>
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<tbody>
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<td>daily/often/rarely</td>
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</table>

1. Do you use a spacer with your inhaler? Yes No
   If yes, which type?
2. Do you own a home nebulizer? Yes No
3. Do you own a peak flow monitor? Yes No
   If so, please list your best peak flow rate

IV. PREVIOUS ALLERGY EVALUATION
Have you ever had allergy skin testing? Yes No
If yes, when
Were you on allergen immunotherapy (allergy shots/drops)? Yes No
If yes, when
Did they help?

V. ENVIRONMENTAL SURVEY - HOME
General (Circle answers)
1. Where do you live? House Apartment Trailer Condo Other
2. How long have you lived there? ________ Age of Dwelling: ________
3. Pets (If yes, please specify):
   Cat indoor outdoor both
   Dog indoor outdoor both
   Other indoor outdoor both
4. Smokers/Vapers in the house? Yes No
5. Is your home air conditioned? Yes No If yes, central or window?
6. Do you keep your windows closed? Yes No
7. Do you have a humidifier? Yes No if yes, central or room?
8. Do you have an electrostatic air filter? Yes No
9. Do you have moisture problems in your home? Yes No
10. Do you have a basement? Yes No Is it damp?

Bedroom
1. Type of bed? Regular Waterbed/waveless Waterbed/wave
2. Plastic encasement of mattress? Yes No On pillow? Yes No
3. Stuffed animals in bedroom? Yes No How many?
4. Type of pillow: Feather Synthetic Cotton
5. Do you have: Carpet Wood Vinyl flooring

VI. WORK/SCHOOL
1. What is your occupation?  
2. A student? Yes No What grade are you in?
3. What are your hobbies?  
4. Are your symptoms worse at work? Yes No
5. Do you get better on vacation? Yes No
6. How many days did you miss school or work in the past year? ________
7. If child, is he/she in daycare? Yes No
8. How many children in room? ________

Where else have you lived?

VII. FAMILY HISTORY
Does any member of your family have a history of:

<table>
<thead>
<tr>
<th>Who: (father, mother, grandmother, etc.)</th>
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<tbody>
<tr>
<td>Asthma</td>
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<tr>
<td>Hay fever</td>
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<td>Eczema</td>
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<td>Migraines</td>
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<tr>
<td>Recurrent infections</td>
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<tr>
<td>Cystic Fibrosis</td>
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<tr>
<td>Insect Sting Reactions</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
### MEDICAL PROBLEMS
Review of Systems - Please circle any applicable problems

**Constitutional:** fever    weight loss    weight gain    fatigue    irritability

**Eyes:** swelling around eye    discharge    contact lens    glaucoma    cataracts

**ENT:** hearing loss    recurrent ear infections    hayfever    runny/itchy nose

**Cardiac:** palpitations    chest pain    high blood pressure    heart disease

**GI:** nausea    vomiting    heart burn    stomach pain    diarrhea    liver disease    ulcer

**GU:** pain of urination    difficulty urinating    frequent urination    blood

**Musculoskeletal:** joint swelling    bone pain    frequent broken bones    osteoporosis

**Skin:** eczema    hives    itching    sores in mouth    thrush

**Neurologic:** headaches    numbness    seizures    weakness    migraines

**Psychiatric:** Allergies affecting the quality of life? **Yes No**

**Hematologic:** anemia    swollen glands    bleeding    HIV positive

**Other Problems** (circle all that apply)
- Diabetes
- Thyroid disease
- Tuberculosis
- Bowel disease
- Arthritis
- Cancer
- Asthma

### SURGERY/OPERATIONS
Circle surgeries and give year
- Ear tubes
- Nasal/Sinus surgery
- Tonsillectomy/Adenoidectomy
- Other

**Have you had chicken pox?**  **Yes No**  **Vaccine**

**SMOKING HISTORY**  **Yes No**  **How much?**  **How often?**
- For how many years?  **When did you stop?**

**VAPING HISTORY**  **Yes No**  **How much?**  **How often?**
- For how many years?  **When did you stop?**

**Have you had all your childhood immunizations?**  **Yes No**
**Do you get a flu shot every year?**  **Yes No**
**Have you had the Pneumovax vaccine?**  **Yes No**

### IX. MEDICATION ALLERGY

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<tr>
<th>Medication</th>
<th>Reaction</th>
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### X. OTHER ALLERGIES

- **Do you have eczema or hives? (circle)**  **Yes No**
- **Have you ever had an allergic reaction to an insect sting?**  **Yes No**
- If yes, what happened?
- **Are you allergic to any foods?**
<table>
<thead>
<tr>
<th>Food</th>
<th>Reaction</th>
<th>Date</th>
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**Have you ever had itching, sneezing or swelling after dental exam or GYN exam?**  **Yes No**
**Have you ever had a reaction after using any of the following? (circle)**
- balloons
- rubber products
- elastic bandages
- condom
**Urticaria/Angioedema Section**

*(Fill out only if you are being seen for Hives or Swelling)*

1. How long have you had hives/swelling?  
2. Briefly describe the circumstances surrounding their onset:

2a. How often do you experience hives?

3. What medications are you taking for the hives/swelling?

4. How long does each individual hive last?  
   - <24 hours  
   - >24 hours

5. Do they itch?  
   - Yes  
   - No

6. Are they painful?  
   - Yes  
   - No

7. Do you experience shortness of breath, wheeze, chest tightness, abdominal pain, throat fullness, dizziness or diarrhea? (circle applicable symptoms)
   - Yes  
   - No

8. Have you recently experienced fevers, chills, night sweats, swollen glands, swollen joints, weight gain or loss? (circle applicable symptoms)
   - Yes  
   - No

9. What “triggers” the hives/swelling (circle)
   - stress  
   - vibration  
   - exercise  
   - medications  
   - friction  
   - home  
   - food  
   - pressure  
   - work  
   - heat  
   - sunlight  
   - cold  
   - water  
   - other  
   - do not know

11. Do you have a family history of hives/angioedema?  
   - Yes  
   - No

12. Have you ever had hives / angioedema in the past?  
   - Yes  
   - No

   If yes, when & how long did they last?

---

**Insect Section**

*(Fill out only if you are being seen for Insect Allergy)*

1. My reaction to an insect sting occurred on:  
   - Month  
   - Year

2. Please describe the location of sting and what happened at the time of the sting.

3. What caused the sting?  
   - Bee  
   - Wasp  
   - Yellow Jacket  
   - Hornet  
   - Ant  
   - Unknown

4. The symptoms that occurred after the sting included (please circle)
   - Swelling at the site  
   - Distant swelling (i.e. lips, tongue)  
   - Hives  
   - Loss of consciousness  
   - Trouble breathing  
   - Trouble swallowing  
   - Vomiting  
   - Dizziness

5. I received treatment at an emergency room  
   - Yes  
   - No

   If yes, which one?

   - They gave me  
     - Benadryl  
     - Epinephrine  
     - Steroids  
     - IV fluids  
     - I don’t know

6. I have an EpiPen, Auvi-Q, or other epinephrine auto-injector.  
   - Yes  
   - No

7. Have you ever been stung before?  
   - Yes  
   - No

8. If yes, when and describe the reaction

---

**PROVIDER COMMENTS**  
*(Do not write in this space)*
In order to accommodate the needs and requests of as many patients as possible, Atlanta Allergy is contracted with numerous insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon what type of contract your employer negotiated with that carrier on your behalf.

Providing quality medical care for our patients is our primary concern.

We are happy to provide care for our patients, within their insurance contract guidelines, but we ask that our patients come prepared at the time of service to let us know what those guidelines are. With most of our contracts, Atlanta Allergy personnel are not permitted to interpret insurance benefits for the patient. We are expected and obligated to provide quality care to each insured person, but it is the insured person’s responsibility to understand their benefits.

Should your insurance company require a specialist referral from your primary care physician before you can be seen by our physicians, it is your responsibility to obtain that referral prior to your appointment. You should bring the referral with you to your appointment. Our contracts with those insurance companies prohibit us from seeing you without a referral and billing them for the services. If you are seen without a referral, you must be prepared to pay for all services in full at the time they are rendered. If a referral is required and you are unsure as to how to obtain one, please let the staff know and we will be happy to provide assistance.

If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains a pre-existing clause, your insurance carrier will likely deny payment for services received. Please remember that you, the patient, are ultimately responsible for payment on your account.

With your cooperation and help, you should be able to receive all of the insurance benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Atlanta Allergy & Asthma Physicians and Staff

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED.

_________________________________________  ______________________________
(Patient and/or Insured)  (Date)

_______________________________________________
(Print Name)

PF-98 Rev. 8/18
Acknowledgement of Receipt of Notice of Privacy Practices

Part 1:

Patient Name: ________________________________________________________________

Address: ____________________________________________________________ City, State, Zip: __________________________

I have been given a copy of Atlanta Allergy & Asthma Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Atlanta Allergy & Asthma ("the Practice") has the right to change this Notice at any time. I may obtain a current copy by contacting the Practice Privacy Official, or by visiting the Practice website at www.atlantaallergy.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____________________________________________________________ ___________________________
(Signature of Patient or Personal Representative) (Date)

Print Name & Title (e.g., Guardian, Health Care Power of Attorney): ________________________________

Part 2:

Atlanta Allergy & Asthma clinical staff may need to communicate Protected Health Information (PHI), such as test or lab results, via phone. Please let us know what phone number you would like us to call and if we may leave a message:

Phone Number: ____________________________________________________________

___ Yes, you may leave a message
___ No, please do not leave a message

I authorize the Practice to include the following person(s) in any communication regarding my PHI. This is a valid authorization until I revoke this in writing:

Name: ________________________________ Relationship: ____________________________

_____________________________________________________________ ___________________________
(Signature of Patient or Patient Representative) (Contact Number) (Date)

For Practice Use Only: Complete this section if you are unable to obtain signature. If the Patient or personal rep is unable or unwilling to sign the Privacy Acknowledgement, or it is not signed for any other reason, state the reason:

____________________________________________________________________________________

Describe the steps taken to obtain the Patient’s (or personal reps) signature on the Acknowledgement:

____________________________________________________________________________________

Signature of Practice Representative: _________________________ Date: _____________

Patient Account #: ________________________________
Patient Name: ________________________________ DOB: ______________

**Patient Communication Options**

Atlanta Allergy & Asthma (AAA) offers several options to receive practice communications such as appointment confirmations/reminders, clinical care reminders, and occasional practice updates such as office moves or weather closings. These notifications are in addition to the messages you receive through your Patient Portal. If you have not activated your portal account, please call 770 953-3331 or provide your email address below. Our staff will assist you with activation.

Check your preferred option(s) for receiving notifications. You may choose voice, text, OR email - or any combination of the three.

- [ ] Voice Message: Best Phone Number: ________________________________
  Time of day for phone call reminder ___AM (9a-12p) ___Noon (12p-3p) ___PM (3p-8p)

- [ ] Text message: Cell Phone #: ________________________________

- [ ] Email: Email Address: ________________________________

**Appointment Cancellation Policy:**

Your appointment is important to both you and the Atlanta Allergy & Asthma staff.

Patient/Guardian Initial

If you cannot keep your appointment for any reason, please contact us at least 24 hours prior to your scheduled appointment time. If you do not keep your appointment, or cancel without a 24-hour notice, you may be charged a $25 no-show fee.

**Consent to Obtain External Prescription History**

In order to provide the highest standard of care, it is necessary for our physicians to know your prescription medication history. Our electronic health record system will allow us to view your current and past medications which can prevent negative interactions between drugs.

- [ ] I Authorize AAA and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinicalWorks. My prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff of AAA, and it may include prescriptions going back a number of years.

- [ ] I DO NOT Authorize AAA and its Affiliated Providers to view my external prescription history via our electronic health record system, eClinicalWorks.

I understand I can change my authorization by completing a new form at any time and the change will be effective when the new form is received by Atlanta Allergy & Asthma, P.A.

(Signature of patient/authorized representative)  (Print name if other than patient)  (Date)

PF-45 Rev. 9/18
Thank you for choosing Atlanta Allergy & Asthma. Please take a moment and let us know how you heard about our practice.

PATIENT NAME: ___________________________ APPT DATE: ____________

How did you hear about our practice? (Please indicate ALL that apply)

☐ Your Physician: ____________________________
☐ Insurance Co. Booklet/Website: ____________________________
☐ Atlanta Allergy & Asthma Employee: ____________________________
☐ Friend/Family Member: ____________________________

Check ALL that apply:

☐ AAA Website
☐ Google
☐ Other Search Engine (Yahoo/Bing)
☐ Yelp
☐ HealthGrades.com
☐ Vitals.com
☐ Yellow Pages
☐ Outdoor Billboards
☐ WSB AM Radio/Scott Slade
☐ Local News (Radio/TV/Print)
☐ Social Media (Facebook/Twitter)
☐ Health Fair/Community Event
☐ Urgent Care/Pharmacy-based Clinics
☐ Other: ____________________________

______________________________________________________________
Staff:

ACCOUNT NUMBER: ___________________________ OFFICE LOCATION: ________

PF-35 Rev. 3/18
Important Information for your Allergy Skin Test Appointment:

- It is very important to be on time for your skin test appointment. If you arrive late, we may be unable to test you due to time constraints.

- Allow 2-3 hours for skin testing. You will discuss the results with your doctor after the skin test.

- Wear comfortable clothing. You will be asked to take your top off, so do not wear a one-piece outfit.

- Skin testing is a simple series of tiny scratches made on your back with an instrument that has small toothpick-like prongs each containing trace amounts of a single allergen. Your doctor determines the number of tests done according to the history you have given. Skin testing is not painful but can be somewhat uncomfortable. Some describe the prick test sensation as being “like a cat walking over the back.”

- After skin prick testing some patients may also receive intradermal testing. With intradermal tests, a small amount of the allergen is injected under the skin of the arm to see if it causes a reaction. This test feels like pinches.

- Swelling or redness at the skin test sites, which may appear several hours after your testing, are called "delayed reactions" and do not have any significance. Any itching associated with these reactions can be managed with steroid creams and antihistamines. This may persist for several days.

- **It is important to stay off antihistamines for seven (7) days prior to testing. Antihistamines will block the skin test reaction.** (See detailed list of medications included in New Patient Packet and on our website.)

- It is recommended you eat prior to skin testing.
**Important Information about Allergy Skin Testing:**

Patients scheduled for allergy skin testing must stop taking any medications that contain antihistamines as they will affect the results of your test. **This includes both over-the-counter as well as prescription medications.** Do not discontinue antidepressants/psychotropic medications or any other medications without consulting with your prescribing physician. Call your pharmacy or prescribing physician if you are unsure about the names of your medications. **Asthma medications do not affect skin testing. Do not stop your asthma medications.**

The following is a list of medications that must be STOPPED SEVEN (7) DAYS before skin testing:

<table>
<thead>
<tr>
<th>Antihistamines</th>
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<th>Antihistamines</th>
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<tbody>
<tr>
<td>Actifed</td>
<td>Clarinex</td>
<td>Loratadine</td>
<td>Seroquel</td>
</tr>
<tr>
<td>Adapin</td>
<td>Claritin</td>
<td>Ludiomil</td>
<td>Sinequan</td>
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<tr>
<td>Advil Allergy</td>
<td>Clemastine</td>
<td>Levocetirizine</td>
<td>Singlet</td>
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<tr>
<td>Advil PM</td>
<td>Clomipramine</td>
<td>Marezine</td>
<td>Sominex</td>
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<td>Alavert</td>
<td>Cogentin</td>
<td>Meclizine</td>
<td>Sudafl Cold &amp; Allergy</td>
</tr>
<tr>
<td>Allegra</td>
<td>Contrex</td>
<td>Norpramin</td>
<td>Surmontil</td>
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<tr>
<td>Allerhist</td>
<td>Contac</td>
<td>Nortriptyline</td>
<td>Tacaryl</td>
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<td>Allertan</td>
<td>Coricidin</td>
<td>Nyquil</td>
<td>Tandur</td>
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<td>Amitriptyline</td>
<td>Cyproheptadine</td>
<td>Pamelo</td>
<td>Tavist</td>
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<td>Anafranil</td>
<td>Desipramine</td>
<td>Pediaicare</td>
<td>Temaril</td>
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<td>Antivert</td>
<td>Dimetapp</td>
<td>Pediatan</td>
<td>Theraflu</td>
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<td>Diphenhydramine</td>
<td>Periactin</td>
<td>Tofranil</td>
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<td>Ataraz</td>
<td>Doxepin</td>
<td>Phenergan</td>
<td>Triaminic</td>
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<td>Dramamine</td>
<td>Polyhistine</td>
<td>Triavil</td>
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<tr>
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<td>Drixoral</td>
<td>Promethazine</td>
<td>Trimpinrime</td>
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<td>BC Cold</td>
<td>Durahist</td>
<td>Protriptyline</td>
<td>Trinalin</td>
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<td>Duratan</td>
<td>Pyribenzamine</td>
<td>Tylenol Allergy</td>
</tr>
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<td>Dytan</td>
<td>Remeron</td>
<td>Tylenol Cold</td>
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<td>Benztrapin</td>
<td>Elavil</td>
<td>Resperidone</td>
<td>Tylenol PM</td>
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<td>Biohist</td>
<td>Etrafon</td>
<td>Risperdal</td>
<td>Unisom</td>
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<td>Bonine</td>
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<td>Brompheniramine</td>
<td>Fexofenadine</td>
<td>Rynatan</td>
<td>Vicks</td>
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<td>Carboxamine</td>
<td>Hydroxyzine</td>
<td>Ryneze</td>
<td>Xyzal</td>
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<td>Cetirizine</td>
<td>Imipramine</td>
<td>Semprexx</td>
<td>Zonolon</td>
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<tr>
<td>Chlortrimeton</td>
<td>Limbitroli</td>
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<td>Zyrtec</td>
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</tbody>
</table>

**Note:** This list includes the most common antihistamines; however there may be some not listed here. Any over-the-counter medications with the word “Allergy”, most over-the-counter cough and cold medications, and over-the-counter sleep medications may affect testing and should be stopped prior to your appointment. If you have any questions, please call us at 770.953.3331.

The following medications must be STOPPED TWO (2) DAYS before skin testing:

**GI MEDICATIONS (for reflux and indigestion)**

<table>
<thead>
<tr>
<th>GI Medications</th>
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<th>GI Medications</th>
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</thead>
<tbody>
<tr>
<td>Axid</td>
<td>Famotidine</td>
<td>Pepcid</td>
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<tr>
<td>Cimetidine</td>
<td>Nizatidine</td>
<td>Ranitidine</td>
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**ANTIHISTAMINE NASAL SPRAYS**

<table>
<thead>
<tr>
<th>Antihistamine Nasal Sprays</th>
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</tr>
</thead>
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<tr>
<td>Azelastine</td>
<td>Astepro</td>
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<tr>
<td>Astelin</td>
<td>Patanase</td>
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