Information about and agreement to allergy tests and blood sampling

Skin tests and blood sampling are done to find out which substances you are allergic to.
During a skin test (prick test) drops with allergen extracts are placed on the surface of your forearm and are gently pricked into your skin. If the test is positive, a small itchy patch with some swelling and redness will appear after about 10 minutes and usually disappear again within 30 minutes.

I agree to perform skin tests / blood sampling.

Last name, first name: _____ date of birth: _____

Erlangen (date) _____ **signature** ……..

Before skin tests:
6 days before: no antihistamines
3 weeks before: no steroids as pill or injection

This questionnaire is used to detect and narrow down possible allergies. Please take your time to read and answer carefully. If your child is the patient, the questions apply to the symptoms and personal environment of your child.

Do you suffer from the following symptoms? (please tick as appropriate)

☐ Itchy/burning/watering eyes
☐ Palate itching
☐ Frequent cough
☐ Gastrointestinal symptoms
☐ Hay fever
☐ Smell/taste dysfunction
☐ Eczema, nettle rash
☐ Sneezing fits
☐ Permanent cold
☐ Asthma
☐ Shortness of breath: ☐ at rest ☐ during physical activity?

When do you have these symptoms?

☐ less than ☐ more than 4 days a week
☐ less than ☐ more than 4 weeks a year

All year ☐

Particularly in certain months (please tick as appropriate):

Jan.	Feb.	Mar	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Where do you have these symptoms?

☐ Outdoors / Nature
☐ Indoors ☐ at home ☐ office ☐ _____
☐ In bed ☐ in the morning ☐ warm/cold change
☐ During particular activities (work, hobby, housework,…) – which ones? _____
☐ On contact with animals – which ones? _____
☐ Do you have pets or frequent contact with animals – which ones? _____
☐ How long do you have these symptoms? _____
☐ Food intolerance? _____

Are you taking any medication? (Please list everything you´re taking)

☐ No ☐ Yes _____
☐ Drug intolerance? _____

Do you have any other diseases?

☐No ☐Yes – Which ones?

Do any close relatives suffer from allergies, hay fever or asthma?

☐No ☐ Yes

Do you smoke?

☐No ☐ Yes

Are you pregnant?

☐No ☐Yes

Do you plan to get pregnant in the near future?

☐No ☐ Yes

Where/How do you live? (please tick as appropriate)

☐In a rural environment
☐In the city
☐Do you have a garden or trees/plants in front of your home?
☐Do you have many indoor plants?
☐Do you have carpeted floors or many upholstered furniture, fabrics or curtains in your home?
☐Do you own an air humidifier or a tabletop fountain or anything like this?

Can you name things in your environment you might be allergic to?

Are you allergic to any stinging insect?

☐No ☐Yes – which ones?

Did you alredy have allergy testing?

☐No ☐Yes – results:

Do you have an allergy passport?

☐No ☐Yes – please hand it to the doctor together with this questionnaire.

Did you already have hyposensitization/immunotherapy/desensitization?

☐No ☐Yes – which allergen?

When and how long?

Brand name:

Formulation: ☐pills ☐injections ☐liquid

Did your symptoms improve after this therapy?

☐Yes ☐somewhat ☐No

Any side effects?

☐No ☐Yes (please describe)

Currently my allergy is (1 = very bad; 10 = very good)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If there are other things which affect you, cause discomfort or may explain your allergy, please tell the doctor.