

NY Center For
Ear, Nose Throat, Sinus & Allergy, LLP

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SINUS & ALLERGY
FACIAL PLASTIC SURGERY
HEARING & BALANCE DISORDERS
SNORING & SLEEP APNEA
HEAD & NECK SURGERY

Patient Name: _____ **Date of Birth:** _____ **Today's Date** _____

Do you take any of the following Blood Pressure Pills ?
(PLEASE CIRCLE) Labatelol, Metoprolol, Atenolol, Toprol, Lotrel

Have you taken any of the following ALLERGY medications within the past week ?
(PLEASE CIRCLE) Claritin, Allegra, Benadryl, Loratidine, Zyrtec, Tylenol Cold & Sinus,
Clarinex, Clortrimeton.

Are you pregnant? YES NO

Have you ever experienced lip/tongue/mouth swelling, shortness of breath, chest tightness,
and/or wheezing after drinking, eating, or having contact with an irritant?
If yes, please list the cause(s) _____

Are you currently being treated for an upper airway infection ? YES NO

Did you perform any vigorous exercise today before this allergy test? YES NO

Do you have asthma? YES NO If so, have you taken your rescue inhaler? YES NO

Have you ever experienced an INSECT STING REACTION ? (wheezing, shortness of breath,
hives, dizziness, fainting) If yes, specify _____

Disclosure and Consent

As a patient, you have the right to be informed about your condition and any recommended procedures. This disclosure is designed to better inform you so that you may give or withhold informed consent to the procedure. To the patient: I voluntarily request Dr. Kantu as my physician, and such associates, technical assistants, and other health care providers as they deem necessary to treat my condition by way of allergy testing. I understand that my physician and/or associates may discover other or different conditions which require additional or different procedures than those planned. I understand that no warranty or guarantee has been made to me as to result or cure.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks or non treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this consent.

I certify that I am not pregnant and that I will notify the office to stop my treatment if I become pregnant.

Date: _____ Patient / Legally responsible person to sign

Print Name _____ Signature _____