Welcome to PHA’s Asthma and Allergy Evaluation and Education Program!

**Prepare for your appointment**

**Before the visit:**
1. Review and complete all of the information included in this package paying special attention to the *Allergy Testing For Persons With Asthma* handout.
2. Discuss allergy testing and asthma medication coverage with your insurance carrier.
3. Prepare your child (ages 7 and up) for their breathing test by having them blow LARGE soap bubbles.
4. Discontinue any medications listed on the next page of this letter under *Medications to be Discontinued 72 Hours Prior to visit.*

**Appointment day:**
Please arrive 15 minutes before the scheduled appointment time and have the following with you:
1. Completed pre-visit questionnaire
2. 3 written goals for the visit
3. List of questions you would like answered during the visit
4. Asthma Action Plan presently being followed
5. All allergy and asthma medications *taken* in the last year
6. Aero-chamber or holding device
7. Pictures of the bedroom, pets and any worrisome areas in the home such as bathroom or window mold.
8. Wear short sleeves and DO NOT wear lotions or powders on the arms

**Check-In**
Turn in your completed pre-visit questionnaire and any forms you received in your pre-visit package, or from the front desk to the receptionist.

**After you check-in**
One of our clinical staff will check vitals including blood pressure, pulse and respiratory rate, height and weight and review any other necessary medical information.

Your Nurse will spend time with you which will, unless otherwise discussed, include:
1. Educational information on: Understanding Asthma; Triggers & Symptoms; Daily Management
2. Skin allergy testing to clarify what allergies are present
3. Breathing (lung) function test to objectively diagnose or help fine-tune a plan for control of asthma
4. Asthma Control Test (ACT)
Your Doctor will conduct a comprehensive evaluation which will include:

1. A review of the patient’s history regarding symptoms, severity, relation to possible allergen exposure, and response to past treatment
2. Conducting an extended physical exam focusing on the eyes, ears, nose, throat, lungs and skin to look for signs of allergic disease.
3. After the history, medical records, physical exam, review of testing conducted by the nurse, as well as a review of other relevant previous tests, you and the doctor will decide if any further testing is necessary. This may include radiological images such as a sinus CT scan or a chest x-ray.
4. Discussion of an individualized, detailed plan of action will take place.

**Breathing (Lung) Function Tests (ages 7 and up)**

Lung function tests (also called spirometry) are one of the most important tests we do to help manage asthma and other lung illness. It measures airway obstruction and response to treatment with a “bronchodilator Lung function tests”; all are very important in making an initial diagnosis of asthma, determining its severity, and allowing us to determine which medication and dose needed to get the asthma under the best control possible.

**Allergy Skin Tests**

Skin testing involves introducing a small amount of allergen just under the skin surface. The prick tests are done with a sterile, disposable plastic prick test device placed on the arm or back, depending on patient preference and the age and size of the child. The discomfort is generally minimal, even for children. Generally, there won’t be any symptoms other than a small hive where the test was done. Some patients experience mild to moderate itching at the test site if they are allergic to the substance. Test results are available within 15 to 20 minutes after application.

As part of your pre-visit preparation certain medications need to be discontinued **72 hours prior to our appointment** as they may prevent skin tests from reacting. A copy of that list is included in this packet. Please call us if you have any questions regarding medications.

Blood tests may be ordered when skin tests cannot be done, such as on patients taking certain medications, those with skin conditions that may interfere with skin testing or in uncooperative patients.
Your AllerVision Skin Test is the gold standard of allergy testing. To ensure an accurate skin test please reference the guidelines below for some of the more common medications that interfere with allergy testing and how to address them. If you are not sure what a particular medication you are taking is, ask your healthcare professional.

"DO NOT STOP TAKING ANY MEDICATIONS UNTIL YOU HAVE DISCUSSED IT WITH YOUR DOCTOR"

### Antihistamines

**Stop taking them 72-hours prior to the test**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Antihistamines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actifed</td>
<td>Claratin (Loratadine)</td>
</tr>
<tr>
<td>Allegra (Fexofenadine)</td>
<td>Clarinex</td>
</tr>
<tr>
<td>Astelin nasal spray</td>
<td>Dimetapp Cold &amp; Allergy</td>
</tr>
<tr>
<td>Atarax (Hydroxyzine)</td>
<td>Diphenhydramine</td>
</tr>
<tr>
<td>Benadryl</td>
<td>Dramamine/Meclizine</td>
</tr>
<tr>
<td></td>
<td>Elestat eye drops</td>
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<tr>
<td></td>
<td>Optivar eye drops</td>
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<tr>
<td></td>
<td>Patanol eye drops</td>
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<td></td>
<td>Tavist</td>
</tr>
<tr>
<td></td>
<td>Tylenol Allergy Sinus</td>
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<td></td>
<td>Tylenol Cold and Flu</td>
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<td></td>
<td>Tylenol Flu pm</td>
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<tr>
<td></td>
<td>Zyrtec (Cetirizine)</td>
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</tbody>
</table>

### Sleep Aids

**Stop taking them 24-hours prior to test**

Many sleep aids such as Tylenol PM & Unisom Sleep contain antihistamines. If it contains diphenhydramine (Benadryl) or Doxylamine succinate it contains antihistamine.

### Antacid Medications

**Stop taking these the evening prior to your skin test**

Some prescription antacid medications can also have an antihistamine effect. TUMS or ROLAIDS are fine as they simply counteract the acid itself.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Antacid Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pepcid</td>
<td>Zantac (Ranitidine)</td>
</tr>
<tr>
<td>Tagament</td>
<td>(Cimetidine)</td>
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</tbody>
</table>

### Leukotriene Blocking Medications

**Do not take on the morning of visit 2-3 hours prior to test**

Singulair (Monteleukast)  Zyfo (Zileuon)  Accolate (Zafirukast)

### Asthma Inhalers

**These do not interfere with allergy testing, take as prescribed**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Asthma Inhalers</th>
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</thead>
<tbody>
<tr>
<td>Advair</td>
<td>Asmanex</td>
</tr>
<tr>
<td>Aerobid</td>
<td>Atrovent</td>
</tr>
<tr>
<td>Albuterol</td>
<td>Azmacort</td>
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<tr>
<td>Alvesco</td>
<td>Combivent</td>
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<tr>
<td></td>
<td>Dulara</td>
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<td></td>
<td>Duoneb</td>
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<tr>
<td></td>
<td>Flovent (Fluticasone)</td>
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<tr>
<td></td>
<td>Maxair</td>
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<tr>
<td></td>
<td>Pulmicort</td>
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<td></td>
<td>Qvar</td>
</tr>
<tr>
<td></td>
<td>Symbicort</td>
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<tr>
<td></td>
<td>Xopenex (levalbuterol)</td>
</tr>
</tbody>
</table>

### Corticosteroid Nasal Sprays

**These do not interfere with allergy testing, take as prescribed**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Corticosteroid Nasal Sprays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flonase</td>
<td>Nasocort (Fluticasone)</td>
</tr>
<tr>
<td>Nasalide</td>
<td>Omnaris/Zetonna (Ciclesonide)</td>
</tr>
<tr>
<td></td>
<td>Rhinocort</td>
</tr>
<tr>
<td></td>
<td>Veramyst</td>
</tr>
</tbody>
</table>

### Beta Blockers

**Postpone for 24-hours prior to test if possible**

- These do not interfere with allergy testing. This is an anaphylaxis risk safety measure. If you are on a beta blocker, the skin test can be performed 24 hours after your last dose.
- You can take your medicine 30 minutes post skin test.
- Injection immunotherapy is not recommended while on beta blockers however the sublingual drops are safe to take.

### Oral Steroids

- **Short term use and small doses** should have no effect on the skin test. However, it is recommended to be off treatment for a minimum of 2 weeks prior to the skin test with short term use.
- **Long term use and high doses** of oral steroids such as 20 mg Prednisone or 16 mg of Medrol per day are likely to affect skin test results and a blood test will be needed.
Pediatric Healthcare Associates
Allergy Questionnaire

Part 1: Please answer only the sections that apply to you

Complete this section only for: NOSE / THROAT / EARS / EYES / HEAD SYMPTOMS *If none, skip to next section

1) Check all that apply

- itchy nose
- sneezing
- congestion
- decreased smell/taste
- snoring
- runny nose - if yes, is the nasal discharge:
  - clear
  - colored

- sore throat
- itchy throat or palate
- throat clearing
- cough
- hoarseness
- post-nasal drainage - if yes, is the drainage:
  - clear
  - colored

- itchy ears
- plugged ears
- ringing
- hearing loss

- itchy eyes
- watery eyes
- red eyes
- dry/irritated eyes
- swollen lids
- discharge

- headache
- facial pressure or pain

2) When did your symptoms first begin? ___________ When, if so, did they get worse? ___________

3) Are your symptoms:
- seasonal* ❑ all year long ❑ all year long, with seasonal worsening*

* Circle the worst months:
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your symptoms worse:

- Irritants
  - smoke
  - air pollution
  - fumes or car exhaust
  - strong odors or perfumes

- Weather
  - cold air
  - rapid temperature change (e.g. going from cold outdoors to indoor heat)

- Medicine
  - aspirin
  - non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Aleve)

- Allergens
  - grass
  - dust or vacuuming
  - damp or musty area
  - animals, if so specify:
  - Location
    - outdoors
    - indoors
    - daycare
    - home
    - school
    - work

5) Have you had any of the following problems or procedures: * if yes, specify ❑ Yes* ❑ No

- frequent ear infections ❑ PE tubes ❑ nasal or sinus surgery ❑ nasal polyps
- broken nose ❑ frequent sinus infections (how many in a year?)

Complete this section if: ALLERGIC REACTION TO A STING, DRUG, FOOD or other SUBSTANCE * If none, skip to next section
If more than one reaction: answer the same questions for each reaction on a separate page

1) What did you react to? ____________________________

   if stung, where on your body were you stung? ____________________________

2) When did the reaction occur? (date and time of day) ____________________________

3) Length of time from exposure (or sting/injection) until onset of symptoms: ____________________________

4) How long did your symptoms last? ____________________________

5) Briefly describe the reaction: ____________________________

6) Please check any of the following symptoms you had with your reaction:

   - shortness of breath
   - tongue swelling
   - hoarseness or change in voice
   - dizziness or loss of consciousness
   - wheezing or chest tightness
   - throat tightness or trouble swallowing
   - flushing
   - abdominal cramping, diarrhea or vomiting

7) Did you get medical attention? ❑ Yes* ❑ No

   * If yes, was it from:
     ❑ Emergency Room ❑ Urgent Care ❑ Clinic ❑ 911/Medics

8) Treatment (if any) you received: ____________________________

9) Do you have a current EpiPen? ❑ Yes ❑ No
Complete this section only for: CHEST or ASTHMA SYMPTOMS *if none, skip to next section

1) Check all that apply and circle the ones that bother you the most:
- shortness of breath
- wheezing
- chest pain or tightness
- coughing up blood
- recurrent or chronic cough — if yes, is the cough: wet/productive dry

2) When did your symptoms first begin? ____________ When, if so, did they get worse? ____________

3) Are your symptoms: seasonal* □ all year long □ all year long, with seasonal* worsening?
   * Circle worst months: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) How often do you have symptoms? □ 2 or less times a week □ once a day □ 3–6 times a week □ throughout the day

5) Do these symptoms disturb your sleep? □ Yes* □ No
   * If yes, how often? □ 2 or less times a month □ 3–4 times a month □ 2–6 times a week □ every night

6) Have you been intubated or on a ventilator? □ Yes* □ No

7) Have you ever had pneumonia? □ Yes* □ No
   * If yes, how many times?

8) Have you ever had a chest X-ray since your symptoms began? □ Yes* □ No
   * If yes, when?

If you've been prescribed albuterol or have asthma, please answer the following questions:

1) How many puffs of albuterol do you use per day? _______

2) How many canisters of albuterol do you use each month? _______

3) Do you use a spacer with your inhalers? □ Yes* □ No

4) Do you monitor your peak flows? □ Yes* □ No
   * If yes, what is your personal best peak flow? _______
   * What has been the range of your peak flow readings over the past 2 weeks? _______

Complete this section only for: ECZEMA *if none, skip to next section

1) When did your eczema first begin? ____________ When, if so, did it get worse? ____________

2) What parts of your body are most affected? ____________

3) Are your symptoms: seasonal* □ all year long □ all year long, with seasonal worsening*
   * Circle worst months: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your eczema worse:

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Infections</th>
<th>Weather</th>
<th>Medicine</th>
<th>Allergens</th>
<th>Location</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>d smoke</td>
<td>d colds</td>
<td>d cold air</td>
<td>d aspirin</td>
<td>d grass</td>
<td>outdoors</td>
<td>exercise</td>
</tr>
<tr>
<td>d fumes/car</td>
<td>d or flu</td>
<td>d weather changes</td>
<td>d non-steroidal</td>
<td>d dust/vacuuming</td>
<td>indoors</td>
<td>emotion/</td>
</tr>
<tr>
<td>d exhaust</td>
<td>d sinus</td>
<td>d heat</td>
<td>d anti-inflammatory agents</td>
<td>d damp or dusty areas</td>
<td>home</td>
<td>stress</td>
</tr>
<tr>
<td>d air pollution</td>
<td>d infections</td>
<td>d</td>
<td>(e.g. Motrin, Advil, Aleve)</td>
<td>d animals</td>
<td>daycare</td>
<td>laughing</td>
</tr>
<tr>
<td>d strong odors</td>
<td>d</td>
<td></td>
<td></td>
<td>d</td>
<td>work</td>
<td>other</td>
</tr>
<tr>
<td>d odors or</td>
<td></td>
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<td></td>
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<tr>
<td>perfumes</td>
<td></td>
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</tbody>
</table>

| Other: d exercise | d emotion/ stress | d laughing | d other: |

page 2 of 4

Continued on next page
Complete this section only for: HIVES or SWELLING  *if none, skip to next section

1) What is your main problem?  hives  swelling  hives and swelling
2) What parts of your body are affected?  
3) When did your symptoms first begin?  When was your last outbreak?
4) On the average, how long does each outbreak last?
5) How often do outbreaks occur?  daily  times a week  times a month  times a year
6) If you have hives, how long does each individual hive last?  less than 24 hours  more than 24 hours
7) Check any symptoms you have with hives:  itching  burning  tingling  pain  bruising
8) Check all that apply: Symptoms worse in the  spring  summer  autumn  winter
   Symptoms worse in the:  morning  afternoon  evening  night
   Symptoms worse in the:  outdoors  indoors  home  school  daycare  work
   Symptoms worse during:  weekdays  weekends  menstrual cycle
9) During an outbreak, do you have any of the following symptoms?  Yes*  No * If yes, check box.
   shortness of breath  flushing  tongue swelling  throat tightness or trouble swallowing
   wheezing or chest tightness  hoarseness or change in voice  dizziness or loss of consciousness
   joint pain  fever  swollen glands  diarrhea, vomiting or abdominal pain
10) Check the things that make your symptoms worse:

<table>
<thead>
<tr>
<th>Exposure to:</th>
<th>Medicines</th>
<th>Allergens</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>exercise</td>
<td>aspirin</td>
<td>grass</td>
<td>emotion or stress</td>
</tr>
<tr>
<td>cold air</td>
<td>non-steroidal anti-inflammatory agents</td>
<td>dust or vacuuming</td>
<td>other: _________</td>
</tr>
<tr>
<td>sunlight</td>
<td>(e.g. Motrin, Advil, Aleve)</td>
<td>wooded areas</td>
<td></td>
</tr>
<tr>
<td>heat (shower/bath)</td>
<td>ACE inhibitors (e.g. lisinopril)</td>
<td>damp or musty area</td>
<td></td>
</tr>
<tr>
<td>rubbing or scratching vibration (mowing lawn, motorcycling)</td>
<td>other medicines:</td>
<td>latex (balloons, condoms, dental work, latex gloves)</td>
<td></td>
</tr>
</tbody>
</table>

Part 2: Please answer all of the remaining questions

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Medicine</th>
<th>Strength (if known)</th>
<th>Dose and number of times taken per day</th>
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</tbody>
</table>

Allergy History

1) Have you had previous allergy skin testing?  Yes*  No * If yes, when?  
2) Have you ever received allergy shots?  Yes*  No * If yes, specify the years you received them:
   From _____ to _____  Additional years: From _____ to _____  From _____ to _____
   Were the shots helpful?  Yes  No  Did you have any bad reactions?  Yes  No
3) Do you have allergies to any foods?  Yes*  No * If yes, specify:
   Name of food  Allergic reaction(s)  Approximate date of reaction(s)  
   ____________________________________________________________  
   ____________________________________________________________  
   ____________________________________________________________  

page 3 of 4  Continued on next page
Past Medical History

1) Please list all surgeries and hospital stays: (followed by approximate date)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2) Have you ever smoked?  □ Yes* □ No  * If yes, specify.
Are you:  □ a current smoker?  □ a past smoker?  Quit date: ____________
What and how long did you smoke?  □ cigarettes: ___ years  Packs per day: ___
__________________________________________________________________________
□ cigars: ___ years  □ pipe: ___ years

3) Does anyone in your home smoke?  □ Yes* □ No  * If yes, specify.
□ mother □ father □ spouse or partner □ son □ daughter
□ brother □ sister □ roommate □ other: ____________

Family History

Please place a check mark for each relative with the following medical problems:
* If more than one relative has the same medical problem, place a check mark for each one.
Example: 2 brothers with asthma:

<table>
<thead>
<tr>
<th>Medical Problem</th>
<th>Mother</th>
<th>Father</th>
<th>Brother</th>
<th>Sister</th>
<th>Son</th>
<th>Daughter</th>
<th>Grandmother</th>
<th>Grandfather</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
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<td>Emphysema</td>
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<td></td>
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<tr>
<td>Nasal allergy</td>
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<td></td>
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<tr>
<td>Sinus problems</td>
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<tr>
<td>Eczema</td>
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</tbody>
</table>

Environmental History

1) What is/was your occupation or, if you are still a student, your grade in school? ____________
2) What are your hobbies? __________________________________________________________________
3) How long have you lived at your present location? ___ years
4) Location:  □ downtown  □ urban  □ suburb  □ rural/country
5) Type of home:  □ house  □ apartment/condo  □ houseboat  □ mobile home  □ other: ____________
6) Where do you live? (City, town, city neighborhood, or nearest city)? __________________________________________________________________
7) Type of heating:  □ radiant  □ forced air  □ heat pump  □ wood burning stove  □ pellet stove  □ other: ____________
8) Air conditioning:  □ none  □ central  □ window units
9) Air filter:  □ HEPA  □ electrostatic
10) Floor:  Bedroom:  □ carpeting  □ wood/laminate  □ tile  □ cement  □ other: ____________
     Family room:  □ carpeting  □ wood/laminate  □ tile  □ cement  □ other: ____________
11) Mattress:  □ regular  □ foam  □ air mattress  □ waterbed  □ futon  □ other: ____________
12) Pillow:  □ synthetic  □ foam  □ down  □ feather  □ cotton  □ other: ____________
13) Comforter:  □ none  □ down  □ synthetic  □ feather  □ other: ____________
14) Do you have zippered dustmite allergy covers (encasements)?  □ Yes* □ No  * If yes, what item is covered?
□ pillows □ mattress □ comforter □ box springs
15) Do you have any pets?  □ Yes* □ No  * If yes, check all that apply and how many of each animal.
□ cat(s) #____ □ dog(s) #____ □ bird(s) #____ □ guinea pig(s) #____
□ gerbil(s) #____ □ hamster(s) #____ □ rabbit(s) #____ □ other: ____________
Circle all pets that live in or have access to your (or the patient's) bedroom.
16) Do you have a mold or mildew problem in your home?  *If yes, is it a □ minor problem? □ major problem?
Where is it?  □ bathroom □ basement □ kitchen □ window sill □ other: ____________

Thank you
What are allergies?

Allergy problems ("allergies") happen when a person’s immune system overreacts to an allergen. An allergen is any substance that causes the immune system to overreact ("allergic reaction").

How do allergies affect asthma?

For persons with asthma and allergies, exposure to allergens can increase asthma symptoms and trigger asthma attacks. In these individuals, exposure to allergens can also cause symptoms such as sneezing, stuffy nose, or itchy eyes.

Why is allergy testing for inhalant allergens important in asthma?

Inhalant allergens (e.g., pollens, molds, animal dander, and house dust mites) appear to be the most important for children and adults with asthma. Allergic individuals with asthma often experience chest, nose, or eye symptoms soon after they are exposed to inhalant allergens. Food allergens are not a common cause of asthma symptoms.

When should allergy testing be administered in persons with asthma?

The recommendation is that children and adults with persistent asthma receive allergy testing, particularly for indoor inhalant allergens (animal dander, house dust mites, cockroaches, and certain molds). Also, allergy testing can be considered for persons with intermittent asthma.

What does allergy testing look for?

Allergy testing looks for a substance in the body called Immunoglobulin E (IgE). IgE is a cause of allergies. Some individuals have IgE for only one type of allergen (e.g., cat), other individuals have IgE for multiple types of allergens (e.g., cat, cockroach, and ragweed), and others have no IgE for any allergens. Allergy testing can show whether an individual has IgE for zero, one, or more than one allergen.

Allergy testing for persons with asthma usually looks for IgE for inhalant allergens that are known to commonly affect asthma symptoms. Some inhalant allergen sources can be present in any season, such as animal dander, indoor mold, and cockroach. In contrast, levels of pollens and outdoor mold can vary by season, depending on the geographic region.

Also, allergens tested during inhalant allergy testing can vary by geographic region, because some allergens are found only in certain parts of the United States.
How is allergy testing administered?

Allergy testing can use skin testing or blood testing to look for IgE for allergens. Each method has its benefits and its drawbacks.

Compared to blood testing, allergy skin testing provides results more quickly (within one hour). However, not all health-care providers have the resources and knowledge to conduct allergy skin testing. Also, some individuals with asthma cannot receive skin testing because of certain medical problems they have or because of certain medications they take.

If allergy skin testing is not possible, blood testing for allergies can be used. Waiting for allergy blood test results usually takes longer than waiting for allergy skin test results. Persons who receive allergy blood testing usually wait at least one day (or several days or weeks) for their test results.

How are allergy test results used?

Both allergy test results and asthma symptoms are important information for persons with asthma. Because allergies found during allergy testing do not always trigger asthma symptoms, health-care providers can find out if an individual's asthma symptoms relate to his or her allergy test results. Sometimes, allergens found during allergy testing can affect an individual's asthma without him or her realizing it. Health-care providers can use their expertise to assess which allergy test results are most important for each individual with asthma.

If one or more allergens appear to affect an individual's asthma, the recommendation is that the individual reduce or avoid exposure to those allergens. For example, during peak pollen times and peak pollen seasons, persons with asthma who are allergic to pollens are advised to stay indoors with windows closed in an air-conditioned environment.

Another recommendation is that these individuals take multiple actions to avoid exposure to allergens, because single actions alone are not as effective. For example, an integrated pest management program is recommended for persons with asthma who are allergic to cockroaches. Integrated pest management includes: blocking cockroach entry into the home by sealing cracks and holes; removing sources of cockroach food by using sealed food containers and disposing of trash frequently; and, when necessary, applying low-toxicity pesticides (out of the reach of children and pets).

Additional Resources

Centers for Disease Control and Prevention
- Asthma: Basic Information: [http://www.cdc.gov/asthma/faqs.htm](http://www.cdc.gov/asthma/faqs.htm)
- Asthma: A Presentation of Asthma Management and Prevention (Slide Presentation and Speaker Notes): [http://www.cdc.gov/asthma/speakin/default.htm](http://www.cdc.gov/asthma/speakin/default.htm)
- Mold website: [http://www.cdc.gov/mold/default.htm](http://www.cdc.gov/mold/default.htm)

Centers for Disease Control and Prevention and the Task Force on Community Preventive Services

National Heart, Lung, and Blood Institute