Methacholine Challenge Instruction

Patient Name: ___________________________ Appointment: ___________________________
Date and Time: ___________________________

You have been scheduled for a methacholine challenge test. This test is to determine the amount of airway irritability. You will be asked to inhale a mist that contains different concentrations of methacholine. The mist is produced by a device called a nebulizer and inhaled through a mouthpiece. Before the test begins and after each period of inhalation, you will be asked to blow forcefully into a spirometer. The test usually takes about one hour.

1. Instructions for Medications:

No exposure to the following in time period specified prior to challenge:

- Short-acting bronchodilators: Albuterol, Terbutaline
  - Medium-acting bronchodilators:
    - Anticollinergic agents
    - Atrovent (ipratropium)
  - Long-acting bronchodilators: Salmeterol, Formoterol
  - Oral bronchodilators
    - Intermediate-acting Theophyline
    - Long-acting theophyllines
    - SioBid, StoPhylin, Unidur, Uniphylin, Thoedur, Teo-24
    - Standard B2 agonist tablets
    - Long-acting agonist tablets
    - Albuterol-SR, Proventil-SP, Volmax
  - Cromolyn sodium – Intal
  - Nedocromil – Tilade
  - Hydroxazine, cetirizine – Anithistamine
    - Allegra, Clarinex, Claritin, Zyrtec
  - Leukotriene modifiers – Accolate, Singular
  - Steroids – inhaled or pills – at your physician’s instructions

FOODS: No caffeine. This includes coffee or tea that is brewed, instant or iced. No colas or other soft drinks that contain caffeine. No chocolates, including candies, frosting, cookies, pies, cocoa or chocolate milk. No aspirin that contains caffeine, such as Anacin and Excedrin.

DAY OF STUDY

2. On the day of the study, eat only a light meal in the morning and no food three to four hours before the test.

3. If you have wheezing within 24 hours of the test or had a respiratory infection within the past six weeks, contact your physician and reschedule the test. Call 202-687-4982 to reschedule.

4. If you have or had in the past any of the following conditions, do not schedule this test and notify the physician ordering the test:
   - Heart attack or stroke within the last three months
   - Uncontrolled hypertension
   - Aortic or cerebral aneurysm
   - Use of Beta adrenergic medication; Lopressor, Atenalol, Propranolol, Inderal, Nardolol, Corzide, Inderide, Betopic, Timoptic
   - Epilepsy
   - Cardiovascular disease accompanied by bradycardia, vagotonia
   - Peptic ulcer disease
   - Thyroid disease
   - Urinary tract obstruction
   - Using a cholinesterase inhibitor – for Myasthenia Gravis
   - If you are pregnant and/or nursing

5. On the morning of the test complete and sign the patient questionnaire. Bring the completed, signed form and your ordering information from your physician.
Patient Name: __________________________ ID#: __________________________
Age: ___________ Height: _______________ Weight: _______________

1. Has a physician ever told you that you have asthma? YES/NO
2. Have you ever been hospitalized with asthma? YES/NO
3. Did you have respiratory disease as a child? YES/NO
4. Have you experienced asthma symptoms within the last two weeks?
   a. Wheezing YES/NO
   b. Chest tightness YES/NO
   c. Shortness of breath YES/NO
5. If you are a smoker, when did you last smoke: __________________________
6. Have you had a respiratory infection within the last six weeks? YES/NO
7. Have you had a heart attack or stroke within the last three months? YES/NO
8. Do you have high blood pressure? YES/NO
9. Have you been told that you have aortic or cerebral aneurysm? YES/NO
10. Are you pregnant and/or nursing? YES/NO
11. Are you using any of the following medications: Lopressor, Atenolol, Propranolol, Inderal, Nardolol, Corside, Inderide, Betopic, Timoptic? YES/NO
12. Do you have:
   a. Epilepsy YES/NO
   b. Peptic ulcer disease YES/NO
   c. Thyroid disease YES/NO
   d. Urinary tract obstruction YES/NO
13. Do you have Myasthenia Gravis? YES/NO

List all of the medications you have taken in the last 48 hours for asthma, breathing problems, hay fever, heart disease, blood pressure, allergies or stomach problems and the total number of days since your last dose for each medication. If you need more space, use the back of this page.

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Patient Signature: __________________________ Date: __________________________