ALLERGY SURVEY FORM

Suite 1.1 Level 1 ▪ 48 Flemington Road ▪ Parkville VIC 3052
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Today's date:			Unit record number:				
PATIENT DETAILS							
Name:	Age:	❑ Male ❑ Female	Allergy Profile	❑ Food allergy	❑ Eczema	❑ Hayfever	❑ Asthma
				❑ Unexplained hives	❑ Drug allergy	❑ Insect sting allergy	❑ Other _____

MAIN CONCERNS ABOUT YOUR CHILD
1.
2.
3.
4.

FAMILY MEMBER DETAILS AND ALLERGY PROFILE							
Father's name:	Age:	❑ Male ❑ Female	❑ None	☑ Food allergy	❑ Eczema	❑ Hayfever	❑ Asthma
Mother's name:	Age:	❑ Male ❑ Female	❑ None	☑ Food allergy	❑ Eczema	☑ Hayfever	❑ Asthma
Sibling 1 name:	Age:	❑ Male ❑ Female	❑ None	❑ Food allergy	❑ Eczema	❑ Hayfever	❑ Asthma
Sibling 2 name:	Age:	❑ Male ❑ Female	❑ None	❑ Food allergy	❑ Eczema	❑ Hayfever	❑ Asthma
Sibling 3 name:	Age:	❑ Male ❑ Female	❑ None	❑ Food allergy	❑ Eczema	❑ Hayfever	❑ Asthma
Sibling 4 name:	Age:	❑ Male ❑ Female	❑ None	❑ Food allergy	❑ Eczema	❑ Hayfever	❑ Asthma
Sibling 5 name:	Age:	❑ Male ❑ Female	❑ None	❑ Food allergy	❑ Eczema	❑ Hayfever	❑ Asthma

ECZEMA			❑ Yes - give details below	❑ No – go to Question 5
a. Rate your child's eczema control in the past 6 months	❑ Good		❑ Average	❑ Poor
b. At what age did your child's eczema start	❑ < 3 months old		❑ 3-6 months old	❑ > 6 months old
c. Steroid cream/ointment	❑ None	❑ Yes, name(s):		
d. Moisturiser cream/ointment	❑ None	❑ Yes, name (s):		
e. Frequency of steroid ointments use (on average)	❑ ≥ 1x/day		❑ 4-6x/week	❑ ≤ 3x/week
f. Frequency of moisturiser use (on average)	❑ ≥ 4x/day		❑ 2-3x/day	❑ ≤ 1x/day
g. Frequency of bath/showers (on average)	❑ ≥ 2x/day		❑ 1x/day	❑ ≤ 2nd daily
h. Are you currently avoiding use of soap in bath/showers			❑ Yes	❑ No

ASTHMA			❑ Yes - give details below	❑ No - go to Question 6
a. Rate your child's current asthma control	❑ Good		❑ Average	❑ Poor
b. Medication/puffer used to relieve symptoms	❑ None	❑ Yes (name/strength/dose):		
c. Medication/puffer used to prevent symptoms	❑ None	❑ Yes (name/strength/dose):		
d. Is a spacer used to deliver these medications?			❑ Yes	❑ No
e. Asthma attacks In the last 6 months, how far apart do asthma attacks occur? How troublesome are the symptoms for each attack?	❑ No attacks ❑ Not troublesome (treated at home)		❑ Attacks ≥ 6 wks apart ❑ Slightly troublesome (requires oral steroid)	❑ Attacks < 6 wks apart ❑ Very troublesome (requires hospitalisation)
f. When well in the last 6 months, in between attacks, does your child Awaken at night with cough and/or wheeze? Develop asthma symptoms with exercise/exertion?			❑ No ❑ No	❑ Yes ❑ Yes

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HAYFEVER			
		❑ Yes - give details below	❑ No - go to Question 7
a. How troublesome are the symptoms?	❑ Not troublesome	❑ Slightly troublesome	❑ Very troublesome
b. Medication: antihistamines used?	❑ None	❑ Yes (name/strength/dose):	
c. Medication: nasal spray used?	❑ None	❑ Yes (name/strength/dose):	
d. When do symptoms occur? (please tick 1 or more boxes)	❑ Whole year	❑ Summer & spring	❑ Pet exposure
e. How frequent do symptoms occur?	❑ Infrequent (< 4 times/week, < 4 weeks/year)	❑ Frequent (≥ 4 times/week, ≥ 4 weeks/year)	
f. Does hayfever result in any functional impairment?	❑ Normal sleep ❑ Normal work/school function ❑ Normal daily activities/sports	❑ Abnormal sleep ❑ School/work function affected ❑ Daily activities/sports affected	

FOOD ALLERGY		❑ Yes - give details below	❑ No - go to Question 8
	Food 1	Food 2	Food 3
Age: At about what age did the reaction occur?			
Food: What food was involved in the reaction? (e.g. egg, peanuts)			
Meal: In what meal was this food cooked in? (e.g. quiche, peanut butter sandwich)			
Exposure: Was this the first exposure to the food?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Quantity: About how much food was ingested? (e.g. ½ bite, whole slice, ½ teaspoon/tablespoon)			
Onset: How quickly did the reaction occur (e.g. immediately, 10-20 minutes, 2 hours)			
Duration: How long did the symptoms last for? (e.g. a few hours, a few weeks)			
Reaction: Skin symptoms (please tick one or more boxes)	❑ Hives (blotchy rash) ❑ Lip swelling/itch ❑ Eye swelling/itch ❑ Facial swelling	❑ Hives (blotchy rash) ❑ Lip swelling/itch ❑ Eye swelling/itch ❑ Facial swelling	❑ Hives (blotchy rash) ❑ Lip swelling/itch ❑ Eye swelling/itch ❑ Facial swelling
Reaction: Gut symptoms (please tick one or more boxes)	❑ Tummy cramps/pain ❑ Vomiting ❑ Diarrhoea	❑ Tummy cramps/pain ❑ Vomiting ❑ Diarrhoea	❑ Tummy cramps/pain ❑ Vomiting ❑ Diarrhoea
Reaction: Breathing symptoms (please tick one or more boxes)	❑ Tongue swelling ❑ Hoarse voice ❑ Throat itch/tightness ❑ Coughing ❑ Difficulty breathing ❑ Rapid/noisy breathing ❑ Wheezing	❑ Tongue swelling ❑ Hoarse voice ❑ Throat itch/tightness ❑ Coughing ❑ Difficulty breathing ❑ Rapid/noisy breathing ❑ Wheezing	❑ Tongue swelling ❑ Hoarse voice ❑ Throat itch/tightness ❑ Coughing ❑ Difficulty breathing ❑ Rapid/noisy breathing ❑ Wheezing
Reaction: Blood pressure symptoms	❑ Floppy/ Collapse	❑ Floppy/ Collapse	❑ Floppy/ Collapse
Action: What did you do? (please tick one or more boxes)	❑ Observed at home ❑ Antihistamines ❑ Adrenaline/EpiPen ❑ Brought to hospital	❑ Observed at home ❑ Antihistamines ❑ Adrenaline/EpiPen ❑ Brought to hospital	❑ Observed at home ❑ Antihistamines ❑ Adrenaline/EpiPen ❑ Brought to hospital
Further reactions: Has there been a further reaction to this food since then? If yes, please provide further details.			
Skin prick tests (SPT): Has SPT been previously performed?	❑ No	❑ Yes – list doctor/hospital:	
EpiPen: Does your child have an EpiPen or EpiPen Junior?	❑ No	❑ Yes – EpiPen	❑ Yes – EpiPen Junior

DIETARY HISTORY (all patients to complete)									
Can your child tolerate the following common allergenic foods? (tick only one box per food)	Milk	Egg	Wheat	Peanut	Cashew	Almonds	Hazelnut	Walnut	Sesame
Tolerated (a significant quantity)*	❑	❑	❑	❑	❑	❑	❑	❑	❑
Never exposed (to a significant quantity)*	❑	❑	❑	❑	❑	❑	❑	❑	❑
Possible allergic reaction – give details on Question 7	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other foods which your child is avoiding (list):									

* Significant quantity: cow's milk and soy milk > 100 mL; egg > one whole egg; nuts > 1 teaspoon; wheat > 2 teaspoons of Weetbix/Vitabrit