



Today's Date

Unit Record Number

Patient Details

Name

Age

Gender

Allergy Profile

Food allergy Unexplained hives Eczema Hayfever Asthma Drug allergy Insect sting allergy

Others

Main Concerns About Your Child

01.

02.

03.

04.

Family Member Details and Allergy Profile

01

Name

Relationship

Gender

Age

None Food Allergy Eczema Hayfever Asthma

02

Name

Relationship

Gender

Age

None Food Allergy Eczema Hayfever Asthma

03

Name

Relationship

Gender

Age

None Food Allergy Eczema Hayfever Asthma

04

Name

Relationship

Gender

Age

None Food Allergy Eczema Hayfever Asthma



Eczema

Yes - Give details below

No - Next question

A. Rate your child's eczema control

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(⇨)

D. Moisturiser cream/ointment

None

Yes, name(⇨)

E. Frequency of steroid ointments use (on average)

< 3 months old

3-6 months old

> 6 months old

F. Frequency of moisturiser use (on average)

< 3 months old

3-6 months old

> 6 months old

G. Frequency of bath/showers (on average)

< 3 months old

3-6 months old

> 6 months old

H. Are you currently avoiding use of soap in bath/showers

< 3 months old

3-6 months old

> 6 months old

Asthma

Yes - Give details below

No - Next question

A. Rate your child's current asthma

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?

No attacks

Attacks ≥ 6 wks apart

Attacks < 6 wks apart

How troublesome are the symptoms for each attack?

Not troublesome
(treated at home)

Slightly troublesome
(requires oral steroid)

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?

No

Yes

Develop asthma symptoms with exercise/exertion?

No

Yes



Hayfever

Yes - Give details below No - Next question

A. How troublesome are the symptoms?in the past 6 months Not trouble- Slightlytroublesome Verytroublesome

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) Whole year Summer & Spring Pet exposure

E. How frequent do symptoms occur? In frequent < 4 times/week, < 4 weeks/year Frequent ≥ 4 times/week ≥ 4 weeks/year

F. Does hayfever result in any functional impairment? Normal sleep Abnormal sleep
 Normal work/school function School/work function affected
 Normal daily activities/sports Daily activities/sports affected

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)*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Never exposed (to a significant quantity)*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Possible allergic reaction vgive details on "Food Allergy Section"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other foods which your child is avoiding (list):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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



Food Allergy <input type="checkbox"/> Yes - Give details below <input type="checkbox"/> No			
Age: At about what age did the reaction occur?	Food 1	Food 2	Food 3
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Quantity: About how much food was ingested? (e.g. 1/2 bite, whole slice, 1/2 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)	<input type="checkbox"/> Hives (blotchy rash) <input type="checkbox"/> Lip swelling/itch <input type="checkbox"/> Eye swelling/itch <input type="checkbox"/> Facial swelling	<input type="checkbox"/> Hives (blotchy rash) <input type="checkbox"/> Lip swelling/itch <input type="checkbox"/> Eye swelling/itch <input type="checkbox"/> Facial swelling	<input type="checkbox"/> Hives (blotchy rash) <input type="checkbox"/> Lip swelling/itch <input type="checkbox"/> Eye swelling/itch <input type="checkbox"/> Facial swelling
Reaction: Gut symptoms (please tick one or more boxes)	<input type="checkbox"/> Tummy cramps/pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Tummy cramps/pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Tummy cramps/pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea
Reaction: Breathing symptoms (please tick one or more boxes)	<input type="checkbox"/> Tongue swelling <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Throat itch/tightness <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Rapid/noisy breathing <input type="checkbox"/> Wheezing	<input type="checkbox"/> Tongue swelling <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Throat itch/tightness <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Rapid/noisy breathing <input type="checkbox"/> Wheezing	<input type="checkbox"/> Tongue swelling <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Throat itch/tightness <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Rapid/noisy breathing <input type="checkbox"/> Wheezing
Reaction: Blood pressure symptoms	<input type="checkbox"/> Floppy/ Collapse	<input type="checkbox"/> Floppy/ Collapse	<input type="checkbox"/> Floppy/ Collapse
Action: What did you do? (please tick one or more boxes)	<input type="checkbox"/> Observed at home <input type="checkbox"/> Antihistamines <input type="checkbox"/> Adrenaline/EpiPen <input type="checkbox"/> Brought to hospital	<input type="checkbox"/> Observed at home <input type="checkbox"/> Antihistamines <input type="checkbox"/> Adrenaline/EpiPen <input type="checkbox"/> Brought to hospital	<input type="checkbox"/> Observed at home <input type="checkbox"/> Antihistamines <input type="checkbox"/> Adrenaline/EpiPen <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes – list doctor/hospital:		
EpiPen: Does your child have an EpiPen or EpiPen Junior?	<input type="checkbox"/> No <input type="checkbox"/> Yes –EpiPen <input type="checkbox"/> Yes –EpiPen Junior		