ALLERGY HISTORY QUESTIONNAIRE

Name: ……………………………………….. D.O.B: …………… Age: ……………

Address: ……………...................................... Tel. No: ……………………

……………………………………………

Sex: Male / Female

School:……………………………………………Class:…………

Name of Family Doctor (GP): ……………………………… Telephone:…………

Address ……………………………………………………………………………

ABOUT YOUR CHILD'S ALLERGY:

1. What is your child allergic to: ……………………………………………

2. **Please tick the symptoms which best describe your child's allergic reaction:**
   - Itchiness of skin
   - Skin rash – eg hives, blotchiness
   - Itchy swollen eyes
   - Itchiness / tingling sensation in the mouth and throat
   - Swelling of face / lips / mouth / tongue / body
   - Feeling sick (nausea)
   - Vomiting / Diarrhoea
   - Abdominal pain / distension
   - Cough / Wheeze
   - Difficulty breathing / tightness in chest
   - Changes in voice (hoarseness)
   - Feeling faint / dizzy
   - Looking very pale
   - Lips /mouth blue in colour
   - Restlessness
   - Collapse / unconscious
   - Other……………………………………………………………

3. What medication has your child been prescribed medication:

4. At what age did your child have their first reaction: ………………………
5. Describe the first reaction:
   ……………………………………………………………………………………..
   ……………………………………………………………………………………..
   ……………………………………………………………………………………..
6. When was your child's last reaction: ……………………………..
7. Describe the last reaction:
   ………………………………………………………………………………………
   …………………………………………………………………………………………
   ……………………………………………………………………………………
8. Did your child require hospital treatment Yes /No
9. Who diagnosed your child's anaphylaxis ***Please circle one of the following***

   GP / Hospital Paediatrician / Casualty Officer / Allergy specialist
10. Has you child had a skin test / blood test to confirm the allergy Yes / No

10. **If yes** when was the test done: ………………………

11. What was the result of the test: ……………………

12. **If no** is your GP referring to an Allergy clinic Yes / No

13. Does your child have any medical condition Yes / No

    If yes please give brief details
    ……………………………………………………………………………………...
    ………………………………………………………………………………………
    ………………………………………………………………………………………

14. Does your child have Asthma : Yes / No

If yes is the asthma mild or severe …………………………………………

Are the symptoms well controlled Yes / No

15. Can your GP be contacted for further information if required: Yes / No

Signed: …………………………………………………Date:…………………………..

Thank you for taking the time to complete this questionnaire