Food Allergy Form

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ Contact information: _____

MEDICAL HISTORY

Specify below:

Current medications:

Have you ever been hospitalized due to an allergic reaction?

◯ Yes ◯ No

If yes, please provide date(s) and details:

FOOD ALLERGIES

Please tick which food/drink triggers your allergy. Indicate the reaction trigger (ingestion, smells, touch) and then the severity of the allergic reaction (mild, moderate, severe/anaphylaxis). You can also provide additional information, such as the date of the last reaction and other notes.

Milk/dairy

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ Severity: _____

Date of last reaction/remarks:

Eggs

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ Severity: _____

Date of last reaction/remarks:

Fish

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

Shellfish

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

Tree nuts

Please specify which tree nut(s): _____

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

Peanuts

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

Wheat

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

Soy

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

OTHERS

Trigger 1

Specify below: _____

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

Trigger 2

Specify below: _____

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

Trigger 3

Specify below: _____

Triggers my allergy:

◯ Yes ◯ No

Reaction trigger: _____ **Severity:** _____

Date of last reaction/remarks:

COMMON SYMPTOMS DURING ALLERGIC REACTIONS

Check all that apply:

- ☐ Hives/rash
- ☐ Throat tightness
- ☐ Nausea
- ☐ Diarrhea
- ☐ Swelling
- ☐ Other
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Vomiting
- ☐ Dizziness
- ☐ Loss of consciousness

FOOD INTOLERANCES (NON-ALLERGIC REACTIONS)

Please list any food intolerances and associated symptoms:

DIETARY RESTRICTIONS

Check all that apply:

- ☐ Religious
- ☐ Cultural
- ☐ Medical
- ☐ Personal choice

Please specify:

EMERGENCY RESPONSE PLAN

1. Does the patient carry an epinephrine auto-injector?

◯ Yes ◯ No

Brand: _____ **Location carried:** _____

2. Does the patient carry an antihistamine?

◯ Yes ◯ No

Brand: _____ **Location carried:** _____

EMERGENCY CONTACTS

Emergency contact #1

Name: _____ **Relationship:** _____

Primary contact no.: _____ **Secondary contact no.:** _____

Emergency contact #2

Name: _____ **Relationship:** _____

Primary contact no.: _____ **Secondary contact no.:** _____

Emergency contact #3

Name: _____ **Relationship:** _____

Primary contact no.: _____ Secondary contact no.: _____

HEALTHCARE PROVIDER INFORMATION

1. Allergist/ immunologist: _____ Medical facility/organization: _____

Contact information: _____ 2. Primary care physician: _____

Medical facility/organization: _____ Contact information: _____

CONSENT AND AUTHORIZATION

I confirm that the information provided is accurate and complete to the best of my knowledge. I authorize the sharing of this information with relevant staff members and emergency responders as needed.

Signature:

Date: _____ dd / mm / yyyy