MACCS medical group
Melbourne Allergy Centre & Children's Specialists

Allergy Survey Form

S

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

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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(s) →	
D. Moisturiser cream/ointment	☐ None	☐ Yes, name(s) →	
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	

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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 sleept	☐ 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)*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Never exposed (to a significant quantity)*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Possible allergic reaction vgive details on "Food Allergy Section"	☐	☐	☐	☐	☐	☐	☐	☐	☐
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

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Food Allergy	☐ Yes - Give details below	☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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)	☐ 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		

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