

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:

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:

- | | |
|---|--|
| <input type="checkbox"/> Hives/rash | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Throat tightness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Other | |

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 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