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CLINICAL HISTORY FORM
Allergic Reactions

This form includes type in fields and tick boxes that can be completed by the patient (or their parent/carer) and provided to the patient's doctor or nurse practitioner before, or at the time of their appointment. The completed form can be saved and emailed, or printed out.

This form includes four sections:

- **SECTION 1**: PATIENT DETAILS - to be completed for new patients, or if details have changed.
- **SECTION 2**: GENERAL INFORMATION - includes 10 questions about the patient's clinical history.
- **SECTION 3**: EVENT RECORD FOR ALLERGIC REACTIONS - this also available as a separate form to complete if there are multiple allergic reactions.
- **SECTION 4**: FURTHER INFORMATION - for details about the patient's clinical history not covered in other sections.

SECTION 1: PATIENT DETAILS (to be completed for new patients or if details have changed)

Patient name: _____

Gender: _____ Date of birth: _____

Address: _____

Medicare number, reference number and expiry date: _____

Private health insurance: _____

Name of referring GP: _____

Email (if patient is 16 years or older): _____

Mobile (if patient is 16 years or older): _____

Occupation: _____

Parent/carer/emergency contact name/s: _____

Parent/carer/emergency contact mobile number/s: _____

Parent/carer/emergency contact email/s: _____

Section 2 is on the next page.

SECTION 2: GENERAL INFORMATION (about the patient's clinical history)

If this form is completed by a parent or carer on behalf of a patient, please note that the following 10 questions relate to the patient, not the parent or carer. More details can be entered in section 4.

1. Do you have any confirmed allergies? ☐ Yes ☐ No

If YES, please provide details: _____

2. Do you have suspected allergies to:

- Foods? ☐ Yes ☐ No
- Insects or ticks (stings or bites)? ☐ Yes ☐ No
- Medications (drugs)? ☐ Yes ☐ No
- Other? ☐ Yes ☐ No

If you replied YES to any of the above, please provide details: _____

3. Are you taking any of the following allergy or asthma medications:

- Antihistamines? ☐ Yes ☐ No
- Eyedrops? ☐ Yes ☐ No
- Nasal sprays? ☐ Yes ☐ No
- Asthma puffers? ☐ Yes ☐ No
- Eczema creams? ☐ Yes ☐ No

If you replied YES to any of the above, please provide details: _____

4. Do you have a prescribed adrenaline (epinephrine) injector (e.g. EpiPen?) ☐ Yes ☐ No

5. Are you taking any other medications, supplements or herbal medications? ☐ Yes ☐ No

If you replied YES, please provide details: _____

6. Do you have any of the following:

- Allergic rhinitis (hay fever)? ☐ Yes ☐ No
- Asthma? ☐ Yes ☐ No
- Eczema? ☐ Yes ☐ No
- Hives? ☐ Yes ☐ No
- Regular headaches? ☐ Yes ☐ No
- Sinus problems? ☐ Yes ☐ No
- Itchy mouth after eating raw fruit or vegetables? ☐ Yes ☐ No

If you replied YES to any of the above, please provide details: _____

7. Do you live in a house with indoor pets? ☐ Yes ☐ No

If you replied YES, please provide details: _____

8. Do you live in a damp house? ☐ Yes ☐ No

9. Is there a family history of allergies, asthma, eczema or allergic rhinitis? ☐ Yes ☐ No

If you replied YES, please provide details: _____

10. Do you have any other medical problems not listed above, including surgeries? ☐ Yes ☐ No

If you replied YES, please provide details: _____

Section 3 is on the next page.

SECTION 3: EVENT RECORD FOR ALLERGIC REACTIONS

This is also available as a separate form to complete if there are multiple allergic reactions to record. More details can be entered in section 4.

Date and time of reaction: _____

Suspected trigger/s (if known):

☐ Food/s: _____

☐ Insects or Ticks (stings or bites): _____

☐ Drug/s (medication/s): _____

Signs/symptoms

Mild or moderate:

☐ Hives
☐ Tingling mouth
☐ Swelling of lips
☐ Vomiting
☐ Abdominal pain

Severe (anaphylaxis):

☐ Tightness in throat
☐ Difficult/noisy breathing
☐ Difficulty talking/hoarse voice
☐ Swelling of tongue
☐ Swelling in throat
☐ Persistent dizziness
☐ Collapse
☐ Pale and floppy
☐ Wheeze
☐ Persistent cough

Location of reaction:

☐ Home ☐ School ☐ Early Childhood Education/Care ☐ Work ☐ Dining out

☐ Other: _____

Activity immediately before reaction:

☐ Eating ☐ Gardening ☐ Exercise ☐ Other: _____

Other medical conditions:

☐ Asthma ☐ Other: _____

Previous allergic reactions:

☐ Mild to moderate ☐ Severe (anaphylaxis)

☐ Allergen/s: _____

Adrenaline (epinephrine) autoinjector prescribed:

☐ Yes ☐ No

How was the allergic reaction managed?

Was adrenaline administered? ☐ Yes ☐ No

Was any other treatment given? ☐ Yes ☐ No

If you replied YES, please provide details: _____

Was an ambulance called? ☐ Yes ☐ No

Other information: _____

Section 4 is on the next page.

SECTION 4: FURTHER INFORMATION (about the patient's clinical history)

This section is for details about the patient's clinical history not covered in other sections.