Food allergy questionnaire: children

For parents and carers of children who have reacted to a food.

Please type your answers into this form (or print and fill it in), save it, and email it to **referrals@vidamedical.com.au** at least **7 days before your appointment**. Skip anything that doesn't apply. If you are completing this for a child, answer for the child.

About you

Full name

Date of birth

Today's date

Phone and email

Completed by (if not the patient)

Usual GP and clinic

Your child's reactions

Use one column per reaction. Start with the most recent and the worst one.

Question	Reaction 1	Reaction 2	Reaction 3
Food you suspect			
Form (raw, cooked, baked, in formula or breast milk)			
How much? (a lick, a teaspoon, a serve)			
Eaten, touched, or via breast milk?			
Date or child's age			
First time having it?			
Time until symptoms started			
What happened? (in order)			
How long did it last?			
Treatment given			
Ambulance, ED or hospital?			
Unwell or running around at the time?			
Had it again since? What happened?			

Symptoms your child has had

- ☐ Hives
- ☐ Swelling of lips, eyes or face
- ☐ Red rash around the mouth
- ☐ Vomiting straight after eating
- ☐ Repeated vomiting 1 to 4 hours after eating
- ☐ Diarrhoea
- ☐ Blood or mucus in poo
- ☐ Wheeze or noisy breathing
- ☐ Hoarse cry or voice
- ☐ Pale and floppy
- ☐ Very sleepy
- ☐ Eczema flare later

Feeding history

Breastfed, formula (which brand?) or both

Age solids started

Food	Age first eaten	Eats it now?	What happened?
Peanut			
Egg			
Cow's milk			
Wheat			
Soy			
Sesame			
Cashew			
Other tree nuts			
Fish			
Shellfish			

Your child's health

- ☐ Eczema
- ☐ Asthma or wheeze
- ☐ Hay fever
- ☐ Born early
- ☐ Growth or weight concerns
- ☐ Fussy or restricted eating

Age eczema started, and how severe (mild, moderate, severe)

Childcare, kindergarten or school

Other people who care for your child (grandparents, childcare)

Impact

How much is your worry about food affecting your family?

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

Medicines

All medicines you take, including sprays, creams, vitamins and supplements

Do you take any of these?

- ☐ Antihistamines (e.g. Telfast, Zyrtec, Claratyne)
- ☐ Blood pressure or heart medicines
- ☐ Regular ibuprofen or aspirin
- ☐ Adrenaline autoinjector (EpiPen / Anapen)

Autoinjector expiry date (if you have one)

Family history

Does a parent, brother or sister have:

- ☐ Food allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay fever
- ☐ Hives
- ☐ Not sure

Your goals

What would you most like to get out of this appointment?

Previous allergy tests (type, date, result). Please bring copies if available.

Before you arrive

Medicines: antihistamines and some other medicines can affect allergy testing. We'll email you instructions on which to pause and when. **Keep taking your asthma medicines.**

Bring: previous test results, photos of any reactions, and your adrenaline autoinjector if you have one.

Your information is confidential and stored in your medical record in line with our privacy policy.