

Family Food Allergy Health History Form

Student Name: _____ Date of Birth: _____
 Parent/Guardian: _____ Today's Date: _____
 Home Phone: _____ Work: _____ Cell: _____
 Primary Healthcare Provider: _____ Phone: _____
 Allergist: _____ Phone: _____

1. Does your child have a diagnosis of an allergy from a healthcare provider: No Yes

2. History and Current Status

<p>a. What is your child allergic to?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Peanuts</td> <td><input type="checkbox"/> Insect Stings</td> </tr> <tr> <td><input type="checkbox"/> Eggs</td> <td><input type="checkbox"/> Fish/Shellfish</td> </tr> <tr> <td><input type="checkbox"/> Milk</td> <td><input type="checkbox"/> Chemicals _____</td> </tr> <tr> <td><input type="checkbox"/> Latex</td> <td><input type="checkbox"/> Vapors _____</td> </tr> <tr> <td><input type="checkbox"/> Soy</td> <td><input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish/Shellfish	<input type="checkbox"/> Milk	<input type="checkbox"/> Chemicals _____	<input type="checkbox"/> Latex	<input type="checkbox"/> Vapors _____	<input type="checkbox"/> Soy	<input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)	<input type="checkbox"/> Other: _____		<p>b. Age of student when allergy first discovered: _____</p> <p>c. How many times has student had a reaction? <input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> More than once, explain: _____</p> <p>d. Explain their past reaction(s): _____</p> <p>e. Symptoms: _____</p> <p>f. Are the food allergy reactions: <input type="checkbox"/> Same <input type="checkbox"/> Better <input type="checkbox"/> Worse</p>
<input type="checkbox"/> Peanuts	<input type="checkbox"/> Insect Stings												
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<input type="checkbox"/> Soy	<input type="checkbox"/> Tree Nuts (walnuts, pecans, etc.)												
<input type="checkbox"/> Other: _____													

3. Trigger and Symptoms

- a. What are the early signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)* _____
- b. How does your child communicate his/her symptoms? _____
- c. How quickly do symptoms appear after exposure to food(s)? _____secs. _____mins. _____hrs. _____days
- d. Please check the symptoms that your child has experienced in the past:
- | | | | | | |
|-------------------|--|---|-------------------------------------|-----------------------------------|---|
| <i>Skin:</i> | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Rash | <input type="checkbox"/> Flushing | <input type="checkbox"/> Swelling (face, arms, hands, legs) |
| <i>Mouth:</i> | <input type="checkbox"/> Itching | <input type="checkbox"/> Swelling (lips, tongue, mouth) | | | |
| <i>Abdominal:</i> | <input type="checkbox"/> Nausea | <input type="checkbox"/> Cramps | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | |
| <i>Throat:</i> | <input type="checkbox"/> Itching | <input type="checkbox"/> Tightness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Cough | |
| <i>Lungs:</i> | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Repetitive Cough | | | <input type="checkbox"/> Wheezing |
| <i>Heart:</i> | <input type="checkbox"/> Weak pulse | <input type="checkbox"/> Loss of consciousness | | | |

4. Treatment

<p>a. How have past reactions been treated? _____</p> <p>b. How effective was the student's response to treatment? _____</p> <p>c. Was there an emergency room visit? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>d. Was the student admitted to the hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain: _____</p> <p>e. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____</p> <p>f. Has your healthcare provider provided you with a prescription for medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>g. Have you used the treatment or medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>h. Please describe any side effects or problems your child had in using the suggested treatment: _____</p>
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