Bluff Road Allergy Patient Questionnaire

Q1 - HAYFEVER		□ Yes – give details below	□ No – go to question 2
a) How troublesome are the symptoms?	□ Not troublesome	□ Somewhat troublesome	□ Very troublesome
b) Medication: antihistamines used?	□ None	□ Yes (name/strength/does)	
c) Medication: nasal spray used?	□ None	□ Yes (name/strength/does)	
d) When do symptoms occur? (Please tick 1 or more boxes	□ Whole year	□ Summer & Spring	□ Pet exposure
e) How frequent do symptoms occur	□ Infrequent (<4 times/week)		□ Frequent (≥ 4 times/week, ≥ 4 weeks year)
f) Does hayfever result in any functional impairment	□ Normal sleep □ Normal work/school function □ Normal daily activities and sports		□ Abnormal sleep □ School/work function affected □ Daily activities/sport affected

Q2 - FOOD ALLERGY		□ Yes – give details below	□ No – go to question 3
	Food 1	**Food 2**	**Food 3**
Age- At what age did the reaction occur			
Food – What food was involved in the reaction? (e.g. egg, peanuts)			
Meal – In what meal was the 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. small bite, whole slice, teaspoon, tablespoon)			
Onset – How quickly did the reaction occur? (e.g. immediately, 10-20 min, 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 (Please tick one or more boxes)	□ Floppy/collapse	□ Floppy/collapse	□ Floppy/collapse
Action: What did you do? (Please tick one or more boxes)	□ Observed at home □ Antihistamines □ Adrenaline/Epipen □ Taken to hospital	□ Observed at home □ Antihistamines □ Adrenaline/Epipen □ Taken to hospital	□ Observed at home □ Antihistamines □ Adrenaline/Epipen □ Taken to hospital
Further reactions – Has there been a further reaction to the 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

Q3 - DIETARY HISTORY (All patients to complete)									
Can your child tolerate the following common allergenic foods? (tick only one box per food)	Milk	Egg	Soy	Wheat	Peanuts	Cashews	Almonds	Hazelnut	Walnut
Tolerated (a significant quantity)*	□	□	□	□	□	□	□	□	□
Never exposed (to a significant quantity)*	□	□	□	□	□	□	□	□	□
Possible allergic reaction (give details in question 2)	□	□	□	□	□	□	□	□	□
Other foods which your child is avoiding (please list)									

* Significant quantity such as: cows milk/soy milk > that 100ml; Egg > one whole egg; nuts > 1 teaspoon; wheat> 2 teaspoons of wheatbix/vitabrit

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