Allergy Focused Clinical History Form (Adapted from NICE CG116 2011)

Infant Details

Name: ……

NHS number: ……

DoB: …… Age: …… Months / Weeks

Weight (+centile): ……

Length (+centile) ……

Head Circumference (+centile): ……

Form completed by: …… **Date**: ……

Feeding History

☐ Exclusively breastfed (until……)
☐ Mixed feeding (from ……)
☐ Exclusively Bottle Fed (from ……)

Medication: ……

Types of infant formula tried:
☐ First milk formula: ……
☐ Lactose free formula: ……
☐ Reflux formula: ……
☐ Soya formula: ……
☐ Comfort formula: ……
☐ Other formula: ……

Name of current formula

……

Started Solids? ☐No ☐ Yes (details): ……

……

……

Personal and Family history of allergy

	Infant	Mother	Father	Sibling
Asthma	☐	☐	☐	☐
Atopic Dermatitis (eczema)	☐	☐	☐	☐
Hayfever / allergic rhinitis	☐	☐	☐	☐
Food Allergy(ies) – not intolerance:	☐	☐	☐	☐

Symptom Checklist and History

*and * Refer directly to secondary care*

	Onset: Minutes* (0-120m)	Onset: Hours >2hrs	Description (e.g. duration, frequency, severity)
Digestive System Symptoms			
☐ Vomiting	☐	☐	……
☐ Reflux/GORD	☐	☐	……
☐ Diarrhoea	☐	☐	……
☐ Constipation	☐	☐	……
☐ Blood or mucus in stools	☐	☐	……
☐ Feed refusal or aversion	☐	☐	……
Skin Symptoms			
☐ Atopic dermatitis (Eczema)	☐	☐	……
☐ Urticaria / hives	☐	☐	……
☐ Eye, lip or facial swelling	☐	☐	……
Respiratory Symptoms			
☐ Wheezing	☐	☐	……
☐ Cough or Breathing problems	☐	☐	……
☐ Blocked or runny nose	☐	☐	……
Other Symptoms			
☐ Restlessness or poor sleeping	☐	☐	……
☐ Excessive crying	☐	☐	……
☐ Back arching	☐	☐	……
☐ Faltering growth	☐	☐	……
☐ Anaphylaxis	☐	☐	……