



THE UNIVERSITY OF MICHIGAN
DIVISION OF ALLERGY AND CLINICAL IMMUNOLOGY
Food Allergy Service
Visit Questionnaire

NAME: _____ REGISTRATION #: _____

REFERRING DOCTOR: _____

ADDRESS OF REFERRING DR: _____

1. What problems bring you or your child to an allergist? _____

2. Please place a check mark in front of symptoms you or your child has had in relation to a food ingestion

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Eczema/atopic dermatitis |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Passed out | <input type="checkbox"/> Shock | <input type="checkbox"/> Anaphylaxis |
| <input type="checkbox"/> Behavior changes | <input type="checkbox"/> Itching | <input type="checkbox"/> Other _____ |

3. Please list the foods that have caused problems for you or your child, and the problem each food caused:

<u>Foods</u>	<u>Problems</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Have you or your child been diagnosed with any other allergic conditions?

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Rhinitis | <input type="checkbox"/> Urticaria/Angioedema (hives/swelling) |
| <input type="checkbox"/> Medication allergies | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Venom allergy (i.e. Bee, wasp) |

5. If your child has asthma, how often do they need a rescue medicine (albuterol)

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Less than once a week | <input type="checkbox"/> Twice a week |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Never |

6. Has your child been to the hospital because of asthma?

- | | |
|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Emergency Room Only |
| <input type="checkbox"/> Hospitalized Overnight | <input type="checkbox"/> Intensive Care Unit |

7. Has your child been diagnosed with Eczema?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

8. If your child has eczema, which of the following medications has your child needed for treatment?

- Steroid Creams
- Antibiotics
- Moisturizers
- None
- Oral Steroids
- Antihistamines
- Other crèmes
- All of the above

9. How were you or your child diagnosed with allergies before?

- Skin testing
- Blood Testing

Results: _____

Please bring results of prior skin or blood testing to the office visit if available.

10. Do you or your child have any other medical problems?

- Lung problems
- Kidney problems
- Skin Problems
- Other _____
- Heart problems
- Stomach problems
- Behavior problems

11. Have you or your child been hospitalized before?

No

Yes

Date

Reason

_____	_____
_____	_____
_____	_____
_____	_____

12. What medications are you or your child taking?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

13. Birth History

- a. Were there any problems during pregnancy? N Y _____
- b. Were there any problems during delivery? N Y _____

14. Birth weight _____

a. How was your child fed? (check all that apply)

Breast fed (how many months? _____)

Bottle fed

Which formula (s)? _____

15. Were there any problems tolerating formulas? _____

16. How old was your child when solid food was introduced? _____

