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

( ) Hives	( ) Wheezing	( ) Eczema/atopic dermatitis
( ) Nausea	( ) Vomiting	( ) Diarrhea
( ) Passed out	( ) Shock	( ) Anaphylaxis
( ) Behavior changes	( ) Itching	( ) Other_____

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

Foods	Problems
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

( ) Asthma	( ) Eczema
( ) Rhinitis	( ) Urticaria/Angioedema (hives/swelling)
( ) Medication allergies	( ) Food Allergies
( ) Latex allergy	( ) Venom allergy (i.e. Bee, wasp)

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

( ) Less than once a week	( ) Twice a week
( ) Daily	( ) Never

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

( ) No	( ) Emergency Room Only
( ) Hospitalized Overnight	( ) Intensive Care Unit

7. Has your child been diagnosed with Eczema?

( ) Yes	( ) No

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

( ) Steroid Creams ( ) Oral Steroids
( ) Antibiotics ( ) Antihistamines
( ) Moisturizers ( ) Other crèmes
( ) None ( ) 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 ( ) Heart problems
( ) Kidney problems ( ) Stomach problems
( ) Skin Problems ( ) Behavior problems
( ) Other_____

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? _____

FAMILY HISTORY

1. Do other people in your family have any of the following conditions?
   ( ) Food Allergies ( ) Eczema ( ) Asthma
   ( ) Hay Fever ( ) Drug allergies

2. Are there any other medical problems in your family (please specify)?
   ( ) Heart disease ( ) Lung problems
   ( ) Skin problems ( ) Stomach problems
   ( ) Other_____

ENVIRONMENTAL HISTORY:

Residence: Age ___yrs. How long have you lived there? _____
Basement: ( ) Y ( ) N Obvious mold or mildew? _____
( ) City ( ) Suburb ( ) Rural
Pets: _____

SOCIAL HISTORY

1. Who lives at home? _____

2. During the day, your child is: ( ) At home ( ) In day care
   ( ) At school ( ) At relative's house

3. Are you, your child or your family worried about food allergies? ( ) Y ( ) N

4. Since the diagnosis of food allergy, have you or your child have any increase in tears, sleeplessness, sadness, mood swings or worry? ( ) Y ( ) N

5. Since the diagnosis has tension increased in the home?

   ( ) Not at all ( ) Moderately ( ) Significantly

6. Has your child been the target of teasing or aggressive behavior due to the diagnosis?
   ( ) Y ( ) N

7. In the 6 months since diagnosis, do you believe your anxiety related to the allergy has increased?
   ( ) None ( ) 25% ( ) 50% ( ) 100%

8. Would you like to speak with a Social Worker regarding this diagnosis? ( ) Y ( ) N

9. Would you like to speak with a Nutritionist regarding this diagnosis? ( ) Y ( ) N