Allergy Focused Clinical History Form for Healthcare Professionals

NHS
Nottinghamshire Area Prescribing Committee

Family history of allergy

	Mother	Father	Sibling
☐ Asthma	☐	☐	☐
☐ Eczema	☐	☐	☐
☐ Hayfever / allergic rhinitis	☐	☐	☐
☐ Food Allergy(ies):	☐	☐	☐

Symptom Checklist and History

	Onset Minutes* (0-120m)	Onset Hours >2hrs	Description (e.g. duration, frequency, severity)
Digestive System Symptoms			
☐ Vomiting	☐	☐	.....
☐ Vomiting – *2-6hours consider FPIES*	☐	☐	
☐ Reflux/GORD	☐	☐	.....
☐ Diarrhoea	☐	☐	.....
☐ Constipation	☐	☐	.....
☐ Blood or mucus in stools	☐	☐	.....
☐ Feed refusal or aversion	☐	☐	.....
Skin Symptoms			
☐ Eczema	☐	☐	.....
☐ Urticaria / hives	☐	☐	.....
☐ Eye, lip or facial swelling	☐	☐	.....
Respiratory Symptoms			
☐ Wheezing or cough	☐	☐	.....
☐ Breathing problems	☐	☐	.....
☐ Blocked or runny nose	☐	☐	.....
Other Symptoms			
☐ Restlessness or poor sleeping	☐	☐	.....
☐ Excessive crying	☐	☐	.....
☐ Back arching	☐	☐	.....
☐ Faltering growth	☐	☐	.....

Feeding History

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

Types of Milks tried:

☐ Cow's milk formula: ……
☐ Lactose free formula: ……..……
☐ Reflux/comfort formula: ……..……
☐ Prescription formula: ……..
☐ If breastfed, has mum tried milk free diet: ……

Please consider how long the patient has been on the formula and what symptoms they had/have.

Name of current formula

……..……

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

Other allergens avoiding;……

Patient Details

Name: ……
NHS number: ……..……
DOB: …… Age: …… Months / Weeks
Weight (+centile): ……..……..
Length (+centile) ……..……
Head Circumference (+centile): ……
Form completed by: ……..**Date**:……..

Reviewed May 2025. Next review date May 2028

(Adapted from NICE CG116 2011)