Name: _____ **DOB:** _____ **Date:** _____

Allergic-reaction or Anaphylaxis Questionnaire

To evaluate your reaction calls for team work. Based on the information you provide; I will recommend further evaluation and treatment. Please take your own time to answer the following questions regarding the allergic reaction; try your best to remember details of the event.

1. Give us an overview of your reaction:

_____
_____
_____

2. Describe your symptoms:

_____
_____
_____

3. In your opinion, what caused the symptoms?

_____
_____
_____

4. What did you ingest within 6 hours of the reaction? And how much?
   - ☐ Food, specify: _____
   - ☐ Prescription and OTC Drugs, specify: _____
   - ☐ Alcohol, specify: _____
   - ☐ Supplements, specify: _____
   - ☐ Others, specify: _____

5. How long does the symptoms last?
   ☐_____minutes ☐_____hours ☐_____days ☐_____weeks

6. Where did the reaction happen?
   ☐Home ☐Work ☐School ☐Indoors
   ☐Outdoors ☐Medical Facility (such as operating room or imaging facility) ☐Others: _____

7. What were you doing 6 hours prior to the reaction?

_____
_____

8. What time did the reaction happen?
   ☐Day ☐Night

9. Any bite or stings from insects such as bees, wasps, ants, kissing bugs, spiders etc.?
   ☐Yes, specify: _____
   ☐No

10. Did you use latex before the reaction? (Latex gloves, condoms, rubber bands, balloons, bandages etc.)
    ☐Yes, specify: _____
    ☐No

11. Were you exposed to a known allergen before the reaction?
    ☐Yes, specify: _____
    ☐No

12. Any physical factors such as cold temperature or heat play a role in the reaction?
    ☐Yes, specify: _____
    ☐No

13. Is your reaction related to your menstrual cycle?

☐Yes, specify: _____

☐No

14. Do you think inhalant exposure caused the reaction?

☐Yes, specify: _____

☐No

15. What did you do to relieve the symptoms?

_____

16. What treatments were administered?

☐EpiPen Injection

☐Over the counter Medications

☐Medication name/s: _____

☐Emergency Room visit

☐Hospitalization

☐None

☐Others: _____

a. Did the symptoms resolve? ☐ Yes ☐ No

b. If you went to Urgent Care or hospital, what did the health care provider tell you and what medications did you receive?

_____

17. Did the symptoms recur?

☐Within _____ minutes

☐Within _____ hours

☐Within _____ days

☐Within _____ weeks

18. Are you having recurrent episodes of the reaction?

☐Yes, how often? _____

☐No

19. When was the last reaction?

_____

20. Since your reaction, are you avoiding any trigger?

☐Yes, specify: _____

☐No

21. Has any health care provider ordered tests on you to evaluate the reaction? Please provide us with a copy of the test results.

☐ Chest X-Ray

☐ CT scan

☐ Allergy Tests

☐ Others: _____