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EVENT RECORD FOR Allergic Reactions

This form includes type in fields and tick boxes that can be completed by the patient (or their parent/carer) and provided to the patient's doctor or nurse practitioner before, or at the time their appointment. The completed form can be saved and emailed, or printed out.

Patient name: _____ Date/time of reaction: _____

GP: _____ Specialist: _____

Suspected trigger/s (if known):

☐ Food/s: _____

☐ Insects or Ticks (stings or bites): _____

☐ Drug/s (medication/s): _____

Signs/symptoms

Mild or moderate:

☐ Hives
☐ Tingling mouth
☐ Swelling of lips
☐ Vomiting
☐ Abdominal pain

Severe (anaphylaxis):

☐ Tightness in throat
☐ Difficult/noisy breathing
☐ Difficulty talking/hoarse voice
☐ Swelling of tongue
☐ Swelling in throat
☐ Persistent dizziness
☐ Collapse
☐ Pale and floppy
☐ Wheeze
☐ Persistent cough

Location of reaction:

☐ Home ☐ School ☐ Early Childhood Education/Care ☐ Work ☐ Dining out

☐ Other: _____

Activity immediately before reaction:

☐ Eating ☐ Gardening ☐ Exercise ☐ Other: _____

Other medical conditions:

☐ Asthma ☐ Other:

Previous allergic reactions: _____

☐ Mild to moderate ☐ Severe (anaphylaxis)

☐ Allergen/s: _____

Adrenaline (epinephrine) autoinjector prescribed:

☐ Yes ☐ No

How was the allergic reaction managed?

Was adrenaline administered? ☐ Yes ☐ No

Was any other treatment given? ☐ Yes ☐ No

If you replied YES, please provide details: _____

Was an ambulance called? ☐ Yes ☐ No

Other information: _____