

PEDIATRIC FOOD-INDUCED ANAPHYLAXIS
HISTORY FORM

Date :

Medical File Number :

Address :

Name - Surname :

Telephone Number :

Gender : ☐ Male / ☐ Female

E-mail :

Date of Birth :

Attending Physician :

Culprit Food Allergen	Dairy <input type="radio"/> Eggs <input type="radio"/> Wheat <input type="radio"/> Peanut <input type="radio"/> Nuts <input type="radio"/> Fish <input type="radio"/> Seafood <input type="radio"/> Other :		
Symptoms Recording per System			
Sudden onset of skin symptoms <i>(pruritus or erythema)</i>	YES <input type="radio"/>	NO <input type="radio"/>	
Sudden onset of angioedema <i>(lips or tongue)</i>	YES <input type="radio"/>	NO <input type="radio"/>	
Upper respiratory system symptoms <i>(sudden onset rhinorrhea, sneezing, hoarseness, "barky" cough, throat tightness)</i>	YES <input type="radio"/>	NO <input type="radio"/>	
Lower respiratory system symptoms <i>(shortness of breath / dyspnea, wheezing, cyanosis)</i>	YES <input type="radio"/>	NO <input type="radio"/>	
Blood pressure drop <i>(hypotension, dizziness, syncope)</i>	YES <input type="radio"/>	NO <input type="radio"/>	
Persistent gastrointestinal symptoms <i>(persistent abdominal pain, vomiting)</i>	YES <input type="radio"/>	NO <input type="radio"/>	
Vital Signs (during the episode)			
Blood Pressure	mmHg	SatO ₂	% Heart Rate /min
Anaphylaxis Diagnosis (based on EAACI's definition)			
Anaphylaxis Diagnosis (based on EAACI's definition)		YES <input type="radio"/> NO <input type="radio"/>	
Grade (based on Sampson's criteria)		1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/>	
Medications for future episode prescription			
Adrenaline	YES <input type="radio"/>	NO <input type="radio"/>	
Antihistamine	YES <input type="radio"/>	NO <input type="radio"/>	
Cortisone	YES <input type="radio"/>	NO <input type="radio"/>	
β ₂ -agonist	YES <input type="radio"/>	NO <input type="radio"/>	