TODAY'S DATE	PLEASE ANSWER THE FOR THE PATIENT WHO IS BOOKED FOR THE CONSULTATION (BOTH SIDES OF FORM)	
Name	**Age**	**Date of Birth**
Parent's names (if patient is a minor)		
****Main reason/s for this appointment**** (list all the concerns)		
Please use ✓ where appropriate for problems that are currently an issue/have been an issue since last visit		

Questions	No	Yes: ***Specify briefly****
Have there been any allergy reactions occurring immediately after having **egg, milk, nuts, wheat or seafood**		
Have you (or your child) ever needed to have **adrenaline**		
Have there been reactions to food or drinks eg. **fruit and vegetables, coloured foods, chocolate etc.**		
Are there **special dietary restrictions** in place or avoidance of special food groups avoided such as dairy foods, gluten, nuts, preservatives		
Are there known allergies to **dust mites, pollens, cats, dogs, horses**		

Symptoms	No	Yes: *How long?*	In the past
Eczema			
Rashes under the neck &/or behind the ears			
Rashes on the trunk			
Nappy rashes			
Hives			
Swelling			
Anaphylaxis			
Blocked nose			
Sneezing		If Yes: *Time of day?*	
Snoring /Apnoea *(periods where breathing stops)*			
Asthma attacks		If Yes: *Frequency?*	
Recurrent wheezing		If Yes: *Frequency?*	
Night cough		If Yes: *Frequency?*	
Chest tightness or coughing with exercise		If Yes: *Frequency?*	
Croup attacks *(loud/barking cough and hoarseness)*		If Yes: *Frequency?*	
Feeding problem *e.g. fussy/food fears/food refusal/overeating/other*		If Yes: *Please specify -*	
Poor growth/faltering growth		If Yes: *Onset?*	
Mouth ulcers		If Yes: *Frequency?*	
Reflux (not any force bringing up the food)		If Yes: *Occasional or after every feed?*	
Vomiting		If Yes: *How many times a day?*	
Mucus in the vomit		If Yes: *Every time?*	
Gagging on food		If Yes: *Which foods?*	
Nausea		If Yes: *How often?*	
Frequent loose stools/diarrhoea		If Yes: *How many a day?*	
Constipation		If Yes: *How many days between stools?*	
Abdominal Pains/colic		If Yes: *How often?*	
Bloating/Wind/Gas		If Yes: *How often?*	
Irritable Bowel Syndrome (as diagnosed by the Dr)			
Coeliac Disease (as diagnosed by the Dr)			
Sleep problem		If Yes: *Up how many times a night?*	
Behaviour problem e.g. hyperactive/difficult/irritable		If Yes: *Specify -*	
Learning problems/ADD/**ADHD**/ASD			
Headaches		If Yes: *Migraine? Other?*	
Anxiety		If Yes: *Medication?*	
Depression		If Yes: *Medication?*	
Fatigue/lethargy			

Weight:
Height: **If known, otherwise measurements can be taken during the appointment**

Medications	Type of medication *(please specify)*	Frequency of use & dose if appropriate	New prescription needed *(Y/N)*
SKIN			
	Moisturiser (specify)		
	Steroids (specify)		
	Elidel		
	Other		
ALLERGY SYMPTOM CONTROL			
	Antihistamines *(specify)*		
	Singulair		
	Other		
ASTHMA MEDICATIONS			
	Ventolin/Asmol		
	Asmol		
	Flixotide		
	Seretide		
	Symbicort		
	Redipred		
	Other		
NOSE SPRAYS			
	Saline		
	Dimetapp		
	Avamys		
	Nasonex		
	Rhincort		
	Beconase		
	Telnase		
	Other		
ANAPHYLAXIS			
	EpiPen / EpiPen Jr		
	Anapen / Anapen Jr		
REFLUX			
	Losec (omeprazole)		
	Zantac		
	Somac		
	Other		
GUT HEALTH			
	Probiotics		
CONSTIPATION			
	Lactulose/Duphalac		
	Movicol Junior / Movicol Half		
	Osmolax		
	Other		
VITAMINS/MINERALS			
E.g. multivitamin, Folic acid, Vitamin C, Calcium, Iron, Iodine, Fish Oil, *Other*			
DIET FORMULA			
E.g. Elecare LCP, Elecare Vanilla, Neocate LCP, Neocate, *Other*			