Appendix 2: Allergy-focused Clinical History Form

Patient Details	
Name:	**Date:**
Weight (kg):	**Length (cm):**

Feeding History
☐ Exclusively breastfed from birth ☐ Mixed feeding (from ………………………….……..) ☐ Exclusively bottle-fed (from ……………………..……..) ☐ Started solids (from ……………….) **Source of cow's milk protein thought to cause symptoms:** ☐Breastmilk (dairy consumed by mum: ……………………………) ☐Formula ☐Weaning/solid food

Symptom	**Onset**		**Previously Tried Treatments**
	(0-120min)[1]	**(>2hrs)**	
Lower GI Diarrhoea Blood in stool Constipation	 ☐ ☐ ☐	 ☐ ☐ ☐	
Upper GI Vomiting Reflux/ GORD	 ☐ ☐	 ☐ ☐	
Skin Eczema Urticaria (hives) Eye, lip or facial swelling	 ☐ ☐ ☐	 ☐ ☐ ☐	
Behavioural Inconsolable crying Back arching Feed refusal Poor sleep	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	
Respiratory Wheezing	☐	☐	
Other Anaphylaxis[1] Growth faltering[2]	 ☐ ☐		

Family History of Atopy	
Sibling: ☐Asthma ☐Eczema ☐Hay fever ☐Food Allergy	**Parent:** ☐Asthma ☐Eczema ☐Hay fever ☐Food Allergy

[1] Refer to Allergy Clinic
[2] Refer to local Dietetic Service for urgent appointment
Enquiries only: gst-tr.prescribingsupportdietitians@nhs.net

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