Food Allergy Form

Patient information	
Name:	Date of birth:
Gender:	Contact information:
Medical history	
Current medications	
Have you ever been hospitalized due to an allergic reaction? ☐ Yes ☐ No	
If yes, please provide date(s) and details	

Food allergies

Please tick which food/drink triggers your allergy. Indicate the reaction trigger (ingestion, smells, touch) and then the severity of the allergic reaction (mild, moderate, severe/anaphylaxis). You can also provide additional information, such as the date of the last reaction and other notes.

Food/ingredient	Reaction trigger	Severity	Date of last reaction/remarks
☐ Milk/dairy			
☐ Eggs			
☐ Fish			
☐ Shellfish			
☐ Tree nuts (please specify):			

Food/ingredient	Reaction trigger	Severity	Date of last reaction/remarks
☐ Peanuts			
☐ Wheat			
☐ Soy			

Common symptoms during allergic reactions			
Check all that apply:			
☐ Hives/rash	☐ Difficulty breathing	☐ Throat tightness	☐ Wheezing
☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Dizziness
☐ Swelling	☐ Loss of consciousness	☐ Other:	

Food intolerances (non-allergic reactions)
Please list any food intolerances and associated symptoms:

Dietary restrictions			
☐ Religious	☐ Cultural	☐ Medical	☐ Personal choice
Please specify:			

Emergency response plan	
1. Does the patient carry an epinephrine auto-injector? ☐ Yes ☐ No	
Brand:	Location carried:
2. Does the patient carry an antihistamine? ☐ Yes ☐ No	
Brand:	Location carried:

Emergency contacts

Name	Relationship	Primary contact no.	Secondary contact no.

Healthcare provider information	
Allergist/immunologist	
Name:	
Medical facility/organization:	
Contact information:	
Primary care physician	
Name:	
Medical facility/organization:	
Contact information:	
Consent and authorization	
I confirm that the information provided is accurate and complete to the best of my knowledge. I authorize the sharing of this information with relevant staff members and emergency responders as needed.	
Signature:	Date: