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EVENT RECORD for Allergic Reactions

This document should be completed by the patient (to provide to their doctor or nurse practitioner) or completed by the doctor or nurse practitioner.

Patient name: _____

Date and time of reaction: _____

GP: _____Specialist: _____

Suspected trigger/s (if known)

☐ Food /s _____

☐ Stings or bites (e.g. bee, tick) _____

☐ Drug _____

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 ☐ Childcare ☐ Work ☐ Dining out

☐ Other_____

Activity immediately before reaction:

☐ Eating ☐ Gardening ☐ Exercise ☐ Other: _____

Other medical conditions

☐ Asthma ☐ Other: _____

Previous allergic reactions

☐ Mild-moderate ☐ Severe (anaphylaxis)

Allergen/s_____

Adrenaline autoinjector prescribed

☐ Yes ☐ No