Pediatric Allergy Assessment Form

Patient Information

Child's Name

Date of Birth

Gender

Parent/Guardian Name

Contact Number

Allergy History

Known Allergies (list)

Describe Reaction(s)

Age at Onset

Treatment Given

Medical History

History of Asthma?

History of Eczema?

Family History of Allergy?

Other Medical Conditions

Environmental/Exposure History

Pets at Home?

Exposure to Tobacco Smoke?

Other Notable Exposures

Current Medications

List Current Medications

Additional Notes

Notes