

Amoxicillin Allergy Survey

Name:

Date of Birth: PATIENT STICKER

Date of Allergic Reaction: _____

Health Card Number:

Family Physician:

Background:

Amoxicillin is a penicillin-based antibiotic used to treat many common infections. Adverse reactions to penicillins are reported in as many as 5 to 10% of patients. Often a reaction will lead patients and physicians to avoid prescribing amoxicillin, but many of these are not true allergic reactions. Patients who have experienced serious, or anaphylactic, reactions should not use amoxicillin. There is growing research to show that amoxicillin can be used safely when there has previously been a mild, moderate, or delayed reaction. The following survey will help your physician to understand your reaction, and determine the future risks associated with amoxicillin.

Symptoms:

Please indicate if any of the following symptoms were part of your allergic reaction:

- | | |
|--|---|
| <input type="checkbox"/> Loss of consciousness, fainting, or near fainting | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Difficulty breathing, wheezing | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Swelling of the lips, tongue, or face | <input type="checkbox"/> Anaphylaxis |

If you selected one of the above answers, please STOP HERE. If you did not, then continue below:

What kind of symptoms did you have:

- | | | |
|--------------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Itching | <input type="checkbox"/> Blistering |
| <input type="checkbox"/> Other _____ | | |

When did the symptoms start:

- | | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Within minutes or hours | <input type="checkbox"/> Within 24hrs | <input type="checkbox"/> After 24hrs |
|--|---------------------------------------|--------------------------------------|

How long did the symptoms last:

- | | | |
|--------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Hours | <input type="checkbox"/> Days | <input type="checkbox"/> Weeks |
|--------------------------------|-------------------------------|--------------------------------|

Other reactions or allergies:

Have you had an allergic reaction to another medication(s)?

Has one of your parents had an allergic reaction to amoxicillin?

Assurance of Accuracy:

By signing below, you certify that the information provided in this survey is accurate and complete to best of knowledge. Withholding or providing misinformation will affect your physician's ability to treat you safely, and could lead to very dangerous medical complications.

Patient/Parent Name:

Patient/Parent Signature:

Office Use Only: Immediate Ig-E Severe Challenge