Data Acquisition Sheet

Evaluation of Direct Oral Challenge Clinic in a Rural Ontario Setting – Pilot Project

Participant History

Participant Research ID #: _____

Age (in years): _____

Gender (please check the box associated with patient EMR): □ Male □ Female

PREVIOUS PENICILLIN ALLERGIC REACTION HISTORY

1) Date of Interview: _____
2) Source of Participant Referral (please check the appropriate box):
   □ primary care physician □ specialist □ Other: _____
3) Have you previously reported/experienced a penicillin allergy (please check the appropriate box)?

   □ Yes □ No (if the participant responds "no" they are not eligible for this study)

3) Approximately how old were you, in years, when you had the allergic reaction to penicillin?

   _____

4) Do you remember the nature of the reaction (please check the appropriate box)?

   □ Yes □ No

5) Approximately how many exposures have you had to penicillin? _____

6) Approximately how long (in years) has it been since you were last exposed to penicillin?

   _____

7) What signs or symptoms did you have during the penicillin allergic reaction

   (please list)?_____

   _____

   _____

8) Did you have severe itching (pruritus) only (please check the appropriate box)?

   □ Yes □ No

9) Did you have a minor rash only (please check the appropriate box)?

   □ Yes □ No

10) Has it been 5 years or less since you last had a reaction to penicillin (please check the appropriate box)?

□ Yes □ No □ Unsure

11) Did you have a severe reaction, shock, difficulty breathing (anaphylaxis, bronchospasms) or angioedema (swelling of the lips or tongue) (please check the appropriate box)?

□ Yes □ No □ Unsure

12) Did you suffer a severe skin reaction (Severe Cutaneous Adverse Reaction, SCAR) (please check the appropriate box)?

□ Yes □ No □ Unsure

13) Do you have a history of asthma (please check the appropriate box)?

□ Yes □ No

14) Did you require treatment for the penicillin allergic reaction (please check the appropriate box)?

□ Yes □ No □ Unsure

If yes, what treatment was provided (ie. Steroids, antihistamines, etc.) _____

_____

_____

15) Have you ever been hospitalized as a result of an allergic reaction to penicillin (please check off the appropriate box)?

□ Yes □ No

16) Are you taking any of the following medications (please check all that apply)?

□ Angiotensin Converting Enzymes (ACE) inhibitors

- □ Capeton (captopril)
- □ Vasotec (enalopril)
- □ Prinivil, Zestril (lisinopril)
- □ Lotensin (benazepril)
- □ Monopril (fosinopril)
- □ Altace (ramipril)
- □ Accupril (quinapril)

□ Aceon, Coversyl (perindopril)

□ Mavik (trandolopril)

□ Univasc (moexipril)

□ Angiotensin II Receptor Blockers (ARBs)

□ Beta Blockers (please check all that apply)

☐ Acebutolol (Sectral)

☐ Atenolol (Tenormin)

☐ Bisoprolol (Zebeta)

☐ Metoprolol (Lopressor, Toprol XL)

☐ Nadolol (Corgard)

☐ Nebivolol (Bystolic)

☐ Propranolol (Inderal, InnoPran XL)

☐ Other (please list): _____

□ Corticosteroids (please check off the appropriate boxes)

☐ Cortisone

☐ Prednisone

☐ Methylprednisone

☐ Dexamethasone

☐ Other (please list): _____

□ Antihistamines – If yes, which one(s): _____

17) Participant Co-morbidities (please check all that apply):

□ COPD □ asthma □ cancer □ high blood pressure

□ high cholesterol □ diabetes □ cardiac disease

□ other (please list): _____

18) PENFAST Score: _____

19) Is the participant eligible to participate in the study (please check the appropriate box)?

□ Yes □ No

Why or why not?

_____

_____

_____

20. **Day Seven**: Participant contacted yes/no

Any signs: (hives, rash, itchy skin, altered blood pressure, wheezing, shortness of breath, tightness in the throat area, or/and swollen lips).

_____

Any treatment required: (cream, over the counter medication, primary care visit, ED)

_____

21. **Day Twenty-eight**: Participant contacted yes/no

Any signs: (hives, rash, itchy skin, altered blood pressure, wheezing, shortness of breath, tightness in the throat area, or/and swollen lips).

_____

Any treatment required: (cream, over the counter medication, primary care visit, ED)

_____