



Oral Immunotherapy – Symptom Diary

Participant No : _____ Month: _____ Year: _____

Day of the month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Total allergen dose (mg)																																
Ingestion Time																																
Symptoms	Put a checkmark below if symptoms are present																															
None																																
Pruritus mouth/throat																																
Urticaria																																
Stomach pain																																
Nausea (N)																																
Vomiting (V)																																
Reflux																																
Acute Fatigue																																
Anaphylaxis/Systemic Reaction																																
Global: 😊 😐 😞																																
CoFAR Grade *																																

Medication	Put a checkmark or letter below if medication was used																														
None																															
Antihistamines																															
Antacids																															
Proton-Pump Inhibitor																															
Epinephrine																															
Other : _____																															

Antihistamines: Benadryl: (B) Reactine: (R) Aerius: (A) Claritin: (C) Rupall: (RU) **Other:** Nalcrom (N) Singluair (S)
Antacids: Zantac: (Z) Pepcid: (P) Pepcid Complete: (PC) Gaviscon: (G) **Proton-Pump Inhibitor (PPI):** Prevacid: (PR) Pantoloc: (PA)

*Reviewed by : _____	Date : _____	PI Signature: _____	Date : _____
_____	_____	_____	_____
_____	_____	_____	_____



