

Food Allergy Questionnaire

Name: _____ Date: _____

1. Answer all questions—be sure to enter the date and your name.
2. Be sure to circle numbers or letters in the left-hand margin for every question as follows:
1 = Frequently
2 = Occasionally
3 = Never
4 = Yes
5 = No
3. Be certain to fill in all blanks unless the answer is No or Never.
4. These questions should be answered as an average over the past several months, not just the past 2 weeks.
5. Even if you think you know the cause of these symptoms in your case, still answer Yes and explain.
6. Even if you have any of these symptoms and think they are normal, still answer Yes and explain.
7. Please review these instructions again after you are finished to be sure all the blanks are filled in correctly.

CIRCLE ANSWER

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|-------|---|---|--|
| Y | N | | 1. What food do you crave or eat often? (Example: More than one glass of Coke, tea, or milk a day.) |
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| <hr/> | | | |
| Y | N | | 2. Do any foods make you sick or disagree with you? Please list them. |
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| 1 | 2 | 3 | 3. Are you EVER awakened between the hours of 1AM and 5AM with the following symptoms: Headache, dizziness, stomach cramps, bloating, heartburn, or dry cough? (Circle 1, 2, or 3 and WRITE IN YOUR SYMPTOMS) |
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| Y | N | | 4. Does any member of your family have hay fever, asthma, hives, chronic skin conditions, migraine headache, dizziness, stomach cramps, bloating, dry cough, or sinus condition? Answer Yes or No, then circle the condition(s). Which family members? |
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| <hr/> | | | |
| Y | N | | 5. During childhood, did you have any of the following: Eczema, hay fever, sinus trouble, asthma, or frequent earaches? (Circle which condition) |
| Y | N | | 6. Were you told that you had colic feeding problems as a baby? |

- 1 2 3 7. Do you have itching of the skin, palate, or roof of mouth? (Circle 1, 2, or 3 and write in area of body affected)
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- 1 2 3 8. Do you notice swelling of the ankles, feet, hands, or face on arising in the morning? (Circle 1, 2, or 3 and write in area of body)
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- 1 2 3 **9.** After a full meal in the middle of the day, do you ever experience sleepiness or fatigue 1-2 hours later? Even if you usually eat only a snack for lunch, please choose a time when you would eat a full meal in the middle of the day (Example: After church on Sunday)
- 1 2 3 10. Do you experience a dry cough? How many coughs in 24 hours?
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- 1 2 3 11. Do you eat snacks frequently between meals? What? (Circle 1, 2, or 3 and answer question)
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- 1 2 3 12. Do you have excessive chilling when a sudden change in temperature occurs?
- 1 2 3 13. Do you have migraine headaches? How often?
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- 1 2 3 14. Do you have sinus headaches? How often?
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- 1 2 3 15. Do you have headaches in the back of your head? How often?
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- 1 2 3 **16.** Do you ever experience gas, bloating, abdominal distention, or cramps? (Circle symptoms) How often?
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- 1 2 3 17. Have you noticed numbness of the face, arms, or legs at periodic intervals with no apparent cause? (Circle which area.) How often?
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- 1 2 3 18. Do you have drowsiness, headache, or bloating following the ingestion of a cocktail or glass of beer or wine?
- Y N 19. Are you allergic to penicillin?

1 2 3

20. Do you ever have any diarrhea, even mild or intermittently? How often?

Y N

21. Do you ever experience repeated symptoms on awaking in the morning such as a headache? Can you make the headache go away by eating or drinking any particular food such as coffee or Coke? What food helps to improve the symptoms?

Y N

22. Are there any other reactions or problems you notice with any other particular food? If so, please list.

1 2 3

23. Do you ever clear your throat? How many times per day?

Y N

24. Have you ever had dizziness? Episodic? Spinning by spells? Positional? When you move? How long does the average episode last?

Y N

25. Does your weight fluctuate? How many pounds in one week?
