Allergy Dept.
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Food Allergy Questionnaire

NAME:____ **DATE:**________________________

A. Answer all questions – be sure to enter the date and your name above.
B. Be sure to circle numbers for applicable questions as follows:
   1 = Frequently
   2 = Occasionally
   3 = Never
C. Be certain to fill in all blanks.
D. These questions should be answered as an average over the past several months, not just the past two weeks.
E. Please review these instructions again after you are finished to be sure all the blanks are filled in correctly.

BEGIN QUESTIONNAIRE

1. What foods do you crave or eat often? (Example: More than one glass of Coke, tea or milk a day.)
   ____
   ____
2. Do any foods make you sick or disagree with you? θ No θ Yes Please list:____________________
   ____
3. Are you EVER awakened between the hours of 1:00 a.m. and 5:00 a.m.? θ No θ Yes
   With the following symptoms: Headache, dizziness, stomach cramps, bloating or dry cough?
   1 = Frequently 2 = Occasionally 3 = Never
   (Circle 1, 2 or 3 and write in your symptoms)____________________________________
   ____
   ____
4. Does any member of your family have hay fever, asthma, hives, chronic skin condition, migraine headaches, dizziness, stomach cramps, bloating, dry cough or sinus condition? θ No θ Yes
   Which family member(s)?____
5. During childhood, did you have any of the following: Eczema, hay fever, asthma or frequent earaches?
   θ No θ Yes Which condition(s)?____
6. Were you told that you had colic feeding problems as a baby? θ No θ Yes
7. Do you have itching of the skin, palate or roof of mouth?
   1 = Frequently 2 = Occasionally 3 = Never
   (Circle 1, 2 or 3 and write in area of body affected)________________________________
8. Do you notice swelling of the ankles, feet, hands or face on arising in the morning?

1 = Frequently 2 = Occasionally 3 = Never

(Circle 1, 2 or 3 and write in area of body affected)____

9. After a full meal in the middle of the day, do you ever experience fatigue 1-2 hours later?

θ No θ Yes 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):

____

10. Do you experience a dry cough? θ No θ Yes How many coughs in 24 hours?______________

11. Do you eat snacks frequently between meals?

1 = Frequently 2 = Occasionally 3 = Never

(Circle 1, 2 or 3 and write in what foods)____

12. Do you have excessive chilling when a sudden change in temperature occurs?

1 = Frequently 2 = Occasionally 3 = Never

13. Do you have migraine headaches?

1 = Frequently 2 = Occasionally 3 = Never

14. Do you have sinus headaches?

1 = Frequently 2 = Occasionally 3 = Never

15. Do you have headaches in the back of your head?

1 = Frequently 2 = Occasionally 3 = Never

16. Do you EVER experience gas, belching, bloating, abdominal distension or cramps?

1 = Frequently 2 = Occasionally 3 = Never

(Circle 1, 2 or 3 and write in each symptom)____

17. Have you noticed numbness of the face, arms or legs at periodic intervals for no apparent cause?

1 = Frequently 2 = Occasionally 3 = Never

18. Do you have drowsiness, headaches or bloating following the ingestion of a cocktail, glass of beer or wine? 1 = Frequently 2 = Occasionally 3 = Never

19. Are you allergic to Penicillin? θ No θ Yes

20. Do you EVER have any diarrhea, even mild or intermittently?

1 = Frequently 2 = Occasionally 3 = Never

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

1 = Frequently 2 = Occasionally 3 = Never

(Circle 1, 2 or 3 and write in foods)____

22. Are there any other reactions or problems you notice with any other particular food?

θ No θ Yes Please list:____

____

23. Do you EVER clear your throat? θ No θ Yes How many times per day?____________

24. Have you EVER had dizziness? θ No θ Yes

Episodic? θ No θ Yes

Spinning by spells? θ No θ Yes

Positional? θ No θ Yes

When you move? θ No θ Yes

How long does the average episode last?____

25. Does your weight fluctuate? θ No θ Yes

How many pounds in one week?____

26. Do you ever have thick postnasal drainage? θ No θ Yes

27. Do you have a sensation of a lump in your throat? θ No θ Yes