

**Food Allergy History Questionnaire**

Please read carefully and complete ALL questions:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Age: \_\_\_\_\_ Gender: male    female    Occupation: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Have you ever been told that you have or do you suffer from any of the following conditions?

- \_\_\_\_\_ functional G.I. symptoms (circle all that apply): gas    belching    fatigue after meals
- \_\_\_\_\_ intermittent diarrhea    bloating    cramps    indigestion    alternating diarrhea/constipation
- \_\_\_\_\_ G.E.R.D. (gastro-intestinal reflux disorder)
- \_\_\_\_\_ Peptic Ulcer Disease
- \_\_\_\_\_ I.B.S. (irritable bowel syndrome)
- \_\_\_\_\_ Crohn's Disease
- \_\_\_\_\_ Celiac Disease
- \_\_\_\_\_ Ulcerative Colitis
- \_\_\_\_\_ Spastic Colon
- \_\_\_\_\_ recurrent diarrhea (with other causes ruled out)
- \_\_\_\_\_ dermatitis or eczema
- \_\_\_\_\_ chronic itching
- \_\_\_\_\_ urticaria (hives)
- \_\_\_\_\_ angioedema
- \_\_\_\_\_ psoriasis
- \_\_\_\_\_ allergic conjunctivitis or itchy eyes
- \_\_\_\_\_ dizziness
- \_\_\_\_\_ Meniere's Disease
- \_\_\_\_\_ tinnitus (ringing in the ears)
- \_\_\_\_\_ allergic rhinitis (with "functional GI symptoms") or with negative tests for inhalant allergies
- \_\_\_\_\_ turbinate hypertrophy with nasal airway obstruction
- \_\_\_\_\_ nasal polyps
- \_\_\_\_\_ Upper Airway Resistance Syndrome
- \_\_\_\_\_ obstructive sleep apnea
- \_\_\_\_\_ chronic sinusitis or recurrent sinusitis
- \_\_\_\_\_ canker sores
- \_\_\_\_\_ recurrent sore throats with fever
- \_\_\_\_\_ frequent throat clearing
- \_\_\_\_\_ lump in the throat sensation
- \_\_\_\_\_ intermittent or chronic hoarseness
- \_\_\_\_\_ vocal cord nodules



- 
- Y N 4. Does any member of your family have hay fever, asthma, hives, a chronic skin condition, migraines, dizziness, stomach cramps, bloating, dry cough, or a sinus condition? (circle all that apply and then list which family members are affected.)
- 
- Y N 5. During childhood, did you have any of the following: eczema, hay fever, sinus trouble, asthma, or frequent earaches? (circle all that apply)
- Y N 6. Were you ever told that you had colic as a baby and/or feeding problems? If so, please describe: \_\_\_\_\_
- 1 2 3 7. Do you have itching of the skin or palate (roof of the mouth)?  
If yes, write in area of body affected: \_\_\_\_\_
- 1 2 3 8. Do you notice swelling of the ankles, feet, hands, or face when you wake up in the morning? If yes, write in area of body affected: \_\_\_\_\_
- 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, e.g. after church on Sunday.)
- 1 2 3 10. How often do you experience a dry cough?
- 1 2 3 11. How often do you eat snacks between meals? If so, please list some examples of what you eat: \_\_\_\_\_
- 
- 1 2 3 12. Do you have excessive chilling when a sudden change in temperature occurs?
- 1 2 3 13. Do you get migraine headaches?
- 1 2 3 14. Do you experience facial pain/pressure?
- 1 2 3 15. Do you get headaches in the back of your head?
- 1 2 3 16. Do you get gas, bloating, abdominal distention, or cramping? If so, please circle all that apply to you.
- 1 2 3 17. Do you notice numbness of your face, arms, or legs at periodic intervals with no apparent cause? If so, please circle all that apply to you.
- 1 2 3 18. Do you experience drowsiness, headache, or bloating following the ingestion of a cocktail or glass of beer or wine? If so, please circle all that apply to you.
- Y N 19. Are you allergic to penicillin?
- 1 2 3 20. Do you ever have diarrhea, even mild or intermittent?
- 1 2 3 21. Do you experience repeated symptoms upon waking up in the morning, such as a headache? Can you make the symptoms go away by eating or drinking something (such as coffee or soda)? Please list any foods/drinks that help: \_\_\_\_\_
- 
- Y N 22. Are there any other reactions or problems you notice with any other particular food? If so, please list: \_\_\_\_\_
- 
-

- 
- Y    N                    23. Do you clear your throat? If yes, approximately how many times per day?\_\_\_\_
- Y    N                    24. Have you ever had dizziness? if so, how would you describe it?--  
episodic?    spinning spells?    when you move? (circle one or write your own  
description) \_\_\_\_\_  
How long does the average episode last? \_\_\_\_\_
- Y    N                    25. Does your weight fluctuate? If yes, how many pounds in one week, on  
average? \_\_\_\_\_

Please list anything that you feel we may have missed that may be pertinent to your allergy symptoms:

---

---

---

---

---

---

---

---

---

---

*Thank You,*  
The Allergy Dept. @ Northeast Ear, Nose & Throat Assoc., Inc.  
**570-387-4368**