# Food Allergy Questionnaire

Name: ________________________ DOB: ___________ Date: __________

This questionnaire is designed to help determine if some of your symptoms are related to gastrointestinal problems. Please read each question carefully. Then circle Yes or No to indicate your answer.

| Question | Yes | No |
|---|---|---|
| Are there any foods that you crave or eat frequently? | Yes | No |
| Are there any foods that you dislike? | Yes | No |
| Are you awakened between the hours of 1:00 and 5:00 am with the following symptoms: headaches, dizziness, stomach cramps, bloating, or dry cough? | Yes | No |
| Have any family members had hay fever, asthma, hives, chronic skin condition, migraine headaches, colitis? | Yes | No |
| Did you have any of the following during childhood: eczema, hay fever, asthma or food feeding problems. | Yes | No |
| Do you ever have itching of the skin, palate or roof of mouth? | Yes | No |
| Do you frequently notice swelling of the ankles, feet, hands or face on arising in the morning? | Yes | No |
| Do you have obvious fatigue two to three hours after a meal? | Yes | No |
| Do you eat snacks frequently between meals? | Yes | No |
| Do you have excessive chilling when a sudden change in temperature occurs? | Yes | No |

**Food Allergy Questionnaire (continued)**

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|---|---|---|
| Do you have frequent migraine headaches or pain in the back of the head? | Yes | No |
| Do you experience belching, abdominal distention, bloating or cramps following meals? | Yes | No |
| Have you noticed numbness of the face, arms or legs at periodic intervals for no apparent cause? | Yes | No |
| Do you have drowsiness, headache or bloating following the ingestion of a cocktail, glass of beer or wine? | Yes | No |
| Are you allergic to Penicillin? | Yes | No |