

DAVID L. JETMORE, M.D.
ROHIT BAWA, M.D.
FOOD ALLERGY QUESTIONNAIRE

PATIENT'S NAME _____

THIS QUESTIONNAIRE IS DESIGNED TO HELP DETERMINE IF SOME OF YOUR SYMPTOMS ARE RELATED TO DISTURBED BODY FUNCTIONS. PLEASE READ EACH QUESTION CAREFULLY THEN CIRCLE YES OR NO TO INDICATE YOUR ANSWER.

- YES NO 1. ARE THERE ANY FOODS THAT YOU CRAVE OR EAT FREQUENTLY?
- YES NO 2. ARE THERE ANY FOODS THAT YOU DISLIKE?
- YES NO 3. ARE YOU AWAKENED BETWEEN HOURS OF 1:00 A.M. AND 5:00 A.M. WITH THE FOLLOWING SYMPTOMS: HEADACHE, DIZZINESS, STOMACH CRAMPS, BLOATING OR DRY COUGH?
- YES NO 4. DOES ANY MEMBER OF YOUR FAMILY HAVE HAY FEVER, ASTHMA, HIVES, CHRONIC SKIN CONDITION, MIGRAINE HEADACHES, DIZZINESS, STOMACH CRAMPS, BLOATING OR DRY COUGH?
- YES NO 5. DURING CHILDHOOD, DID YOU HAVE ANY OF THE FOLLOWING: ECZEMA, HAY FEVER, ASTHMA, OR FOOD FEEDING PROBLEMS?
- YES NO 6. DO YOU EVER HAVE ITCHING OF THE SKIN, PALATE, OR ROOF OF MOUTH?
- YES NO 7. DO YOU FREQUENTLY NOTICE SWELLING OF THE ANKLES, FEET, HANDS, OR FACE ON ARISING IN THE MORNING?
- YES NO 8. DO YOU HAVE MARKED FATIGUE TWO TO THREE HOURS AFTER MEALS?
- YES NO 9. DO YOU EAT SNACKS FREQUENTLY BETWEEN MEALS?
- YES NO 10. DO YOU HAVE EXCESSIVE CHILLING WHEN A SUDDEN CHANGE IN TEMPERATURE OCCURS?
- YES NO 11. DO YOU HAVE FREQUENT MIGRAINE HEADACHES OR PAIN IN THE BACK OF YOUR HEAD?
- YES NO 12. DO YOU EXPERIENCE BELCHING, ABDOMINAL DISTENTION, BLOATING, OR CRAMPS FOLLOWING MEALS?
- YES NO 13. HAVE YOU NOTICED NUMBNESS OF THE FACE, ARMS, OR LEGS AT PERIODIC INTERVALS FOR NO APPARENT CAUSE?
- YES NO 14. DO YOU HAVE DROWSINESS, HEADACHES, OR BLOATING FOLLOWING THE INGESTION OF A COCKTAIL, GLASS OF BEER, OR WINE?
- YES NO 15. ARE YOU ALLERGIC TO PENICILLIN?