

## FOOD SENSITIVITY QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

This questionnaire is designed to help determine whether some of your symptoms are related to delayed food sensitivities. Please read each question carefully, fill in all the blanks, circle the applicable symptoms, and fill in the appropriate responses where indicated.

1. What foods do you eat more than once per day? (eg. Milk, bread, candy, cola, etc.)

List the foods \_\_\_\_\_

2. List any foods that make you sick or disagree with you.

List the foods \_\_\_\_\_

3. Are you awakened between the hours of 1:00AM and 5:00 AM with the following symptoms: Headaches, dizziness, stomach cramps, bloating, food cravings, dry cough—circle those that apply to you.

4. Does any member of your family have hay fever, asthma, hives, chronic skin conditions, migraine headaches, dizziness, stomach cramps, bloating, dry cough, or stomach cramps? Circle all that apply.

5. During childhood, did you have any of the following? Eczema, hay fever, asthma, frequent sinusitis, or frequent ear infections. Circle all that apply.

6. Were you told you had colic feeding problems as an infant? YES NO

7. Do you have itching of the skin, palate, or roof of the mouth? YES NO If so, how often does this occur? DAILY WEEKLY MONTHLY

8. Do you notice swelling of the ankles, feet, hands, or face when arising in the morning. Circle all that are applicable.

9. Do you ever have a full, large meal in the middle of the day? YES NO

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IF so, do you experience fatigue 1-2 hours after that meal? YES NO If so, how often? ALMOST ALWAYS HALF THE TIME NOT OFTEN

10. Do you ever have a dry cough? YES NO How often? DAILY WEEKLY MONTHLY

If so, how many times might you cough in 24 hours? 5 10 20 30 40 50 75 100 >100

11. Do you snack between meals? YES NO List the foods you snack on.

List: \_\_\_\_\_

12. Do you have excessive chilling when a sudden change in temperature occurs? YES NO

13. Do you have severe migraine headaches? YES NO How often: Daily Weekly Monthly

14. Do you have sinus headaches? YES NO How often: Daily Weekly Monthly Rarely

15. Do you have headaches in the back of your head? YES NO How often: Daily Weekly

Monthly rarely

16. Do you ever have gas, belching bloating after meals or cramping? YES NO

How Often: Daily Weekly Monthly Rarely

17. Have you noticed numbness of the face, arms, or legs at periodic intervals for no apparent reason? YES NO How often: Daily Weekly Monthly Rarely

18. Do you have drowsiness, headache, or bloating after the ingestion of a cocktail, beer, or wine? YES NO

19. Are you allergic to penicillin? YES NOW

20. Do you ever have diarrhea, even mild or intermittent? YES NO

How often: Daily Weekly Monthly

21. Do you ever have repeated symptoms on awakening in the morning? eg headache.

List the symptoms \_\_\_\_\_

Can you make these symptoms go away by eating or drinking a particular food, such as coffee or cola? List the foods: \_\_\_\_\_

22. Are there any other reactions or problems that you notice with any other foods? List the foods: \_\_\_\_\_

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23. Do you ever clear your throat? YES NO How often: Daily Weekly Monthly

How many times per day? 1-2 5 10 20 30 40 50 75 100 >100

24. Do you ever have dizziness with a sense of motion? YES NO

Does this occur by spells? YES NO

Does this occur when you move your head? YES NO

How long does the average spell last without stopping? 5-10 seconds 1-2 min, 15-30 min

1 or more hours

25. Does your weight increase or decrease by 4-5 pounds in a one week period? YES NO

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