ARNE WELLNESS CENTER
Food Allergy Questionnaire

NAME:_____ Date_____

1. Describe what problems you or your child are having.

_____
_____
_____
_____

2. Please place a check mark in front of symptoms you or your child has had in relation to a food ingestion.

( ) Hives	( ) Wheezing	( ) Eczema/atopic dermatitis
( ) Nausea	( ) Vomiting	( ) (Hives/Swelling)
( ) Passed out	( ) Shock	( ) Anaphylaxis
( ) Itching	( ) Behavior changes	( ) Other_____

3. Please list the foods that have caused problems for you or your child, and the problem food caused:

Foods	Problems
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Have you or your child been diagnosed with any other allergic conditions?

( ) Asthma	( ) Eczema
( ) Rhinitis	( ) Hives/Swelling
( ) Medication allergies	( ) Food Allergies
( ) Latex allergy	( ) Venom allergy (i.e. Bee, Wasp)

5. If you or your child has asthma, how often do they need a rescue medicine (albuterol)?

( ) Less than once a week ( ) Twice a week
( ) Daily ( ) Never

6. Have you or your child been to the hospital because of asthma?

( ) No ( ) Emergency Room Only
( ) Hospitalized Overnight ( ) Intensive Care Unit

7. Have you or your child been diagnosed with Eczema?

( ) Yes ( ) No

8. If you or your child has eczema, which of the following medications have you needed for treatment?

( ) Steroid Creams ( ) Oral Steroids
( ) Antibiotics ( ) Antihistamines
( ) Moisturizers ( ) Other Creams
( ) None ( ) All of the above

9. How were you or your child diagnosed with allergies before?

( ) Skin Testing ( ) Blood Testing

Results:

_____

_____

Please bring results of prior skin or blood testing to the office visit if available.

10. What medications are you or your child taking?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

11. How was your child fed? (check all that apply)

( ) Breast Fed (how many months?_____)
( ) Bottle Fed
Which Formula (s)? _____

12. Were there any pro blems tolerating formulas?_____

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13. How old was your child when solid food was introduced? _____

FAMILY HISTORY

1. Do other people in your family have any of the following conditions?

( ) Food Allergies ( ) Eczema ( ) Asthma
( ) Hay Fever ( ) Drug allergies

2. Are there any other medical problems in your family (please specify)?

( ) Heart Disease ( ) Lung problems
( ) Skin problems ( ) Stomach problems
( ) Celiac Disease ( ) Other_____