



Allergy Questionnaire

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Allergy – 30

Name: _____ DOB: _____ Date: _____

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.

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

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