

Do You Have Food Allergies Or Sensitivities?

This questionnaire is designed to help you and Dr. Koniver determine whether some of your symptoms may be related to delayed food allergies or sensitivities. Please read each question carefully, fill in all the blanks, and circle either *yes* or *no* on the left and the appropriate responses on the right.

Note: For the symptoms asked, *none is normal.*

1. What foods do you eat more than once a day? (Example: cola, tea, milk, bread, candy):

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

Yes No 3. Are you awakened between the hours of 1:00 am and 5:00 am with the following symptoms: headache, dizziness, stomach cramps, bloating, food cravings, or dry cough? Circle your symptoms

Yes No 4. Does any member of your family have hay fever, asthma, hives, Chronic skin condition, migraine headache, dizziness, stomach cramps, Bloating, dry cough, or a sinus condition? Circle the conditions

Yes No 5. During childhood, did you have any of the following: eczema, hay fever Asthma, or frequent earaches? Circle the Conditions

Yes No 6. Were you told that you had colic feeding problems as a baby?

Yes No 7. Do you have itching of the skin, palate, or roof of the mouth? How often does it occur? _____ Daily Weekly Monthly

Yes No 8. Do you notice swelling of the ankles, feet, hands, or face on arising in the morning? Circle area

Yes No 9. Do you ever have a full meal in the middle of the day? (example: after church on Sunday or in a restaurant during the day?)

Yes No 10. Do you ever experience fatigue 1 to 2 hours after that meal How often does it occur? _____ Almost every time Half the time Not very often

Yes No 11. Do you ever have a dry cough? _____ Daily Weekly Monthly How many times might you cough in 24 hours? _____ Circle the number

Yes No 12. Do you eat snacks between meals?

Please list the foods: _____

- Yes No 13. Do you have severe migraine headaches? Daily Weekly
 How often? _____ Monthly Every Several months
- Yes No 14. Do you have excessive chilling when a sudden change in temperature occurs?
- Yes No 15. Do you have sinus headaches? Daily Weekly
 How often? _____ Monthly Every Several Months
- Yes No 16. Do you have headaches in the back of your head? Daily Weekly
 How often? _____ Monthly Every Several Months
- Yes No 17. Do you ever have gas, belching, bloating after meals, or cramps? Daily Weekly
 How often do you have this? _____ Monthly Every Several Months
- Yes No 18. Have you noticed numbness of the face, arms, or legs at periodic intervals for no apparent reason or cause?
 How often? _____ Daily Weekly Monthly
- Yes No 19. Do you have drowsiness, headache, or bloating after the ingestion of a cocktail, beer, or wine?
- Yes No 20. Are you allergic to penicillin?
- Yes No 21. Do you ever have any diarrhea, even mild or intermittent?
 How often? _____ Daily Weekly Monthly
- Yes No 22. Do you ever have repeated symptoms on awakening in the morning such as a headache?
 List other recurring symptoms _____
- Yes No 23. Can you make the symptoms go away by eating or drinking any particular food, such as coffee or cola?
- Yes No 24. Are there any other reactions or problems that you notice with any other foods?
 List these foods: _____

Yes No 25. Do you ever clear your throat?

How often does this occur ? _____ Daily Weekly Monthly

How many times per day? _____ Circle the Number

1-2 5 10 20 30 40 50 75 100 >100

Yes No 26. Do you ever have dizziness with a sense of motion?

Yes No Does this occur by spells?

Yes No When you move your head?

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

Longer than one hour

Yes No 27. Does your weight ever increase or decrease 4 –5 pounds in a 1-week period?

This questionnaire is to be used for informational purposes only and is not meant to diagnose or treat any specific illness or disease.

