Patient Questionnaire

Patient's Name: ____________________ Patient's Date of Birth: ____/_____/______

1. What brings you in today?:
   ____
   ____
   ____

2. Related to the ingestion of a food, what symptoms were experienced?
   Please check all that apply.

( ) Hives ( ) Anaphylaxis ( ) Diarrhea ( ) Difficulty breathing ( ) Vomiting
( ) Itching ( ) Eczema ( ) Nausea ( ) Itchy Throat or Nose ( ) Lethargy
( ) Reflux ( ) Stomach pain ( ) Difficulty Swallowing

3. If you have asthma, how often do you use your rescue inhaler? __________________________

4. Do you have other allergic conditions?
   ( ) Eczema ( ) Rhinitis ( ) Venom Allergy ( ) Angioedema/Urticaria
   ( ) Eosinophilic Gastrointestinal Disease ( ) Celiac Disease ( ) Asthma

5. Have you been previously diagnosed with food allergies? ( ) No ( ) Yes - did you have testing?
   ( ) skin testing or ( ) blood testing

6. Do you have a family history of allergic disease?
   ( ) No
   ( )Yes – family member/allergic disease: _______________/_________________

7. What medications are you taking?
   a. ______________________________
   b. ______________________________
   c. ______________________________