Auckland Allergy Specialists

Food Allergy Questionnaire

In order to help us understand **the patient's** symptoms, we may need to undertake some allergy testing (such as skin prick testing) on the day of your clinic appointment.

We would be grateful if you could complete the following questionnaire and email or bring to the appointment with you?

Name of the patient, if its your child, please add your name as NOK			
Print Name		**Signature**	
Date *dd/mm/yyyy*		NOK	

Food allergies

1. **Are you or your child able to eat any of the following foods?**
Please tick options that apply

	Yes	No	Never had
Milk			
Egg			
Peanuts			
Other nuts			
Fish			
Shellfish			
Wheat			
Sesame			
Other *Please state*			

2. **Are you or your child excluding any of these foods? If yes please say why**
Please tick and answer as appropriate

	Yes	Why?
Milk		
Egg		
Peanuts		
Other nuts		
Fish		
Shellfish		
Wheat		
Sesame		

Other *Please state*		

3. You or your child ever reacted to any of the following foods?

If so, please tick type of reaction

	Type of reaction						
	Sneezing /Cough /Hoarse voice	Wheeze	Swelling	Itchy skin /Hives	Vomiting/ Diarrhoea	Worsening eczema	Other *please write what symptom*
Milk							
Egg							
Peanuts							
Other nuts							
Fish							
Shellfish							
Wheat							
Sesame							
Other *Please state*							

4. You or your child have any of the following?

Tick all that apply

	Yes	No	Not sure
Eczema			
Asthma			
Rhinitis (Hayfever)			
Urticaria (nettle sting rash)			
Drug/Latex allergy			
Allergy to stings			

If yes to Eczema, Asthma or Rhinitis, *please answer the relevant section below*

4 a - Eczema			
	Yes	No	Not sure
Dust			
Pollen			
Animals			
Other			

4 b - Asthma			
Is your asthma made worse by any of the following? *please tick all that apply*			
	Yes	No	Not sure
Dust			
Pollen			
Animals			
Damp/mould			
Thunderstorms			
In the home environment do you have any of the following? *please tick all that apply*			
	Yes	No	Not sure
Damp/Mould			
Smokers			
Pets			

4 c – Rhinitis (hayfever)			
Do you **suffer from the following?** *please tick as appropriate*			
	Yes	No	Not sure
Sneezing/itchy/runny nose			
Nasal congestion			
Itchy, watery eyes			
Loss of taste/smell			

4 d Are the hayfever symptoms *please tick which option applies*						
All year round?						
Worse in particular months?						
If worse in particular months *please tick around which months*	January		May		September	
	February		June		October	
	March		July		November	
	April		August		December	

Family History

5. Is there a family history of the following? *tick as appropriate*

	Mother	Father	Siblings	Other *please state*
Asthma				
Eczema				
Food allergies				
Drug allergies				
Allergy to stings				

Clinic Appointment

6. What do you hope to achieve from this allergy appointment?

Please state below