RPAH ALLERGY UNIT Name _____ Date (dd/mm/yy) ___/___/___

Date of birth (dd/mm/yy) ___/___/___ Age (yrs) _____ Height (cm) _____ Weight (kg) _____ Head Circ. (cm) _____

YOUR CURRENT DIET

Record the **CURRENT TYPICAL FOODS** you (your child) eat.
Don't forget to include items such as stocks, sauces, herbs and spices, butter, margarine and sugar.

Breakfast

Morning Tea

Lunch

Afternoon Tea

Dinner

Supper

SUPPLEMENTS
E.g. vitamins and minerals, fish oil, probiotics, herbals

Commonly eaten **FRUIT** (list)

Commonly eaten **VEGETABLES** (list)

CHECKLIST

FOOD/DRINK	TYPE & FREQUENCY
E.g. Soft drink	*E.g. Lemonade 1x per week*
Herbs / spices	
Stock cubes	
Sauces / dressings	
Oils	
Margarine	
Crackers / crispbreads	
Cake / biscuits	
Chocolate	
Nuts / seeds	
Lollies	
Chewing gum / mints	
Crisps	
Dried fruit	
Water	
Tea (normal/decaf/herbal)	
Coffee (regular/decaf)	
Milk	
Soy / Rice drink	
Formula	
Juice	
Cordial	
Soft drink	
Alcohol	
Eating out / Takeaway	

Have you had any **REACTIONS TO FOODS?**

FOOD	SYMPTOMS

What is your response to eating the following foods?

	OK	Don't like	Never eat	React (list symptoms)
Pears	☐	☐	☐	
Celery	☐	☐	☐	
Cabbage	☐	☐	☐	
Brussel sprouts	☐	☐	☐	
Garlic	☐	☐	☐	
Leek	☐	☐	☐	
Shallot	☐	☐	☐	
Onions	☐	☐	☐	
Legumes / lentils	☐	☐	☐	

Have you (or your child) seen an **ALTERNATIVE PRACTITIONER**/ had **ALTERNATIVE TESTS** performed? ☐ Yes ☐ No

Are you (or your child) **SENSITIVE TO SMELLS**? ☐ Yes ☐ No

Are you (or your child) currently on a **SPECIAL DIET**, or **RESTRICTING** or **AVOIDING ANY FOODS**? (Give details)

Currently: _____

In the Past: _____