Health
NSW Sydney Local Health District
RPAH Allergy Unit

Name _____ Date _____

Date of birth _____ Age (yrs) _____
Height (cm) _____ Weight (kg) _____

DIET SYMPTOM ASSESSMENT QUESTIONNAIRE

This questionnaire will help you, your doctor and your dietitian identify whether you may have food intolerances.

1. Please indicate the main reason(s) for this appointment?

2. Please indicate the symptoms you have CURRENTLY (in the last 6 months)?

SYMPTOM	FREQUENCY					SEVERITY		
	Never	Occas.	Monthly	Weekly	Daily	Mild	Mod.	Severe
EXAMPLE SYMPTOM				☑			☑	
STOMACH PROBLEMS								
Nausea	☐	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐	☐
Reflux	☐	☐	☐	☐	☐	☐	☐	☐
Heartburn	☐	☐	☐	☐	☐	☐	☐	☐
Indigestion								
BOWEL PROBLEMS								
Bloating/Discomfort	☐	☐	☐	☐	☐	☐	☐	☐
Pain/cramps	☐	☐	☐	☐	☐	☐	☐	☐
Diarrhoea	☐	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐	☐
Variable bowel pattern	☐	☐	☐	☐	☐	☐	☐	☐
Wind/Gas								
SWALLOWING PROBLEMS	☐	☐	☐	☐	☐	☐	☐	☐
SKIN								
Hives	☐	☐	☐	☐	☐	☐	☐	☐
Swellings	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Other rash/ itch	☐	☐	☐	☐	☐	☐	☐	☐
ANAPHYLAXIS	☐	☐	☐	☐	☐	☐	☐	☐
RESPIRATORY								
Hay fever /sinus trouble								
Sneezing	☐	☐	☐	☐	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐	☐	☐	☐	☐
Blocked nose/ sinuses	☐	☐	☐	☐	☐	☐	☐	☐
Post-nasal mucus drip	☐	☐	☐	☐	☐	☐	☐	☐
Throat symptoms								
Sore	☐	☐	☐	☐	☐	☐	☐	☐
Itchy	☐	☐	☐	☐	☐	☐	☐	☐
Tight/swollen	☐	☐	☐	☐	☐	☐	☐	☐
Hoarse throat	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Wheeze	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐
NEUROLOGICAL								
Headache/ migraine	☐	☐	☐	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐	☐	☐	☐

Name _____ Date_____

Muscle/Joint aches & pains	☐	☐	☐	☐	☐	☐	☐	☐
Mood changes	☐	☐	☐	☐	☐	☐	☐	☐
Brain fog	☐	☐	☐	☐	☐	☐	☐	☐
HORMONAL PROBLEMS								
Pre-menstrual syndrome (PMS)	☐	☐	☐	☐	☐	☐	☐	☐
Irregular/ painful periods	☐	☐	☐	☐	☐	☐	☐	☐
Polycystic ovary syndrome PCOS)	☐	☐	☐	☐	☐	☐	☐	☐
Endometriosis	☐	☐	☐	☐	☐	☐	☐	☐
OTHER								
Mouth ulcers	☐	☐	☐	☐	☐	☐	☐	☐
Bladder irritation	☐	☐	☐	☐	☐	☐	☐	☐
Vulva/ vaginal irritation	☐	☐	☐	☐	☐	☐	☐	☐
Thrush	☐	☐	☐	☐	☐	☐	☐	☐
Cardiac irregularity/ atrial fibrillation	☐	☐	☐	☐	☐	☐	☐	☐

3. Indicate the OVERALL severity of your symptoms in the last week ☐ **Mild** ☐ **Moderate** ☐ **Severe**

4. AT PRESENT, how much do your symptoms impact on your quality of life? ☐ **Not at all** ☐ **Just a little** ☐ **Pretty much** ☐ **Very much**

5. Do you have any of the following?

	Current	Past	Never	Details
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
Anorexia nervosa	☐	☐	☐	
Bulimia	☐	☐	☐	
Major loss of weight	☐	☐	☐	
Diabetes	☐	☐	☐	
Thyroid disease	☐	☐	☐	
Coeliac disease	☐	☐	☐	
Crohn's disease/Ulcerative colitis	☐	☐	☐	
Eosinophilic Oesophagitis (EoE)	☐	☐	☐	
Food allergy	☐	☐	☐	
Tick bite allergy	☐	☐	☐	

6. Are you currently pregnant? ☐ **Yes** ☐ **No**

7. Do you currently have any other medical conditions? ☐ **Yes** ☐ **No**

If **yes**, please specify:

Name _____ Date_____

8. Do you have any KNOWN ALLERGIES?

a) Drug allergies? ☐ **Yes** ☐ **No**

If yes, list the drug(s) and symptoms provoked by each drug e.g., Antibiotic (specify if known e.g. penicillin), Aspirin, Nurofen, other, etc.

Drugs	Yes / No	List symptoms provoked by drug
Aspirin		
Nurofen		
Other anti-inflammatory drug (specify if known)		
Antibiotic (specify if known)		
Other (specify)		
Other (specify)		

b) Food allergies (confirmed by allergy skin prick test (SPT) or blood test) ☐ **Yes** ☐ **No**

If yes, list the food(s), symptoms provoked by each food, timing and if you are currently completely avoiding each food.

Foods	Yes/No	Symptoms provoked by food	Timing of reactions		Currently avoiding completely Yes/No
			Immediate (<2hrs)	Delayed (>2hrs)	
Egg					
Milk					
Soy					
Wheat					
Sesame					
Peanut					
Walnut					
Hazelnut					
Cashew					
Almond					
Macadamia					
Brazil					
Pine Nut					
Pecan					
Pistachio					
Kiwi					
Fish					
Cod					
Tuna					
Salmon					

Mussel	☐		☐	☐	☐
Prawn	☐		☐	☐	☐
Crab	☐		☐	☐	☐
Lobster	☐		☐	☐	☐
Squid	☐		☐	☐	☐
Calamari	☐		☐	☐	☐
Red Meat	☐		☐	☐	☐
Other (specify)	☐		☐	☐	☐

c) Other allergies (confirmed by allergy skin prick test (SPT) or blood test) ☐ **Yes** ☐ **No**

If yes, list the other allergies and symptoms provoked by each allergy e.g. dust mite, grasses, pollen, mould, animal (cat, dog, horse, other), insect (bee, wasp, other), tick, contact allergy, occupational allergy, other.

Other allergies	Yes / No	List symptoms provoked by other allergies
Dust mite	☐	
Grasses	☐	
Pollen	☐	
Mould	☐	
Tick	☐	
Other (specify)		
Other (specify)		
Other (specify)		

Do you have an Adrenalin autoinjector (e.g. Epipen/Anapen) known allergies? ☐ **Yes** ☐ **No**

Name _____ Date_____

9. Have you modified or restricted your diet? ☐ **Yes** ☐ **No**

If **yes**, please provide details:

Modification/restriction	**Year Modified**	**Reason for modifying**	**Source of the advice** e.g. doctor, naturopath, dietitian, friend/family, internet/magazine/books	**Did it help?** Not at all, just a little, pretty much, very much
Gluten-free diet			please select	please select
Wheat-free diet			please select	please select
Milk-free diet			please select	please select
Lactose-free diet			please select	please select
Low-FODMAP diet			please select	please select
Other "Elimination" diet Specify:			please select	please select
Detox			please select	please select
Vegetarian/Vegan			please select	please select
Belief based diet (Kosher, Halal, Hindu etc.)			please select	please select
Mediterranean diet			please select	please select
Low cholesterol/low fat			please select	please select
Low calorie			please select	please select
Diabetic diet			please select	please select
Other diets (specify)				
			please select	please select
			please select	please select

Name _____ Date_____

10. Have you had any reactions and/or do you avoid particular <u>foods or drinks</u>? ☐ **Yes** ☐ **No**

If **<u>yes,</u>** please describe:

FOOD GROUP	Specify food	SYMPTOM(S) of the worst reaction	Currently Avoiding
EXAMPLE: Fruit	Strawberries	Hives	☑
Bread/cereal/grains			
Vegetables			
Fruit			
Dairy Products			
Meat, fish & eggs			
Sweets & snacks			
Drinks			
Alcoholic drinks			
Other			

Name _____ Date_____

11. What is your response to eating the following foods? *(choose as many as apply)*

	OK	Dislike	Never eat	React – please record your symptoms
Brussels Sprouts				
Cabbage				
Garlic				
Leek				
Legumes/Lentils				
Onion				
Pear				
Shallot				

12. Do smells, fumes or environmental chemicals make you feel unwell? **Yes** **No**

	Not at all	Just a little	Pretty much	Very much	Symptoms
Perfumes					
Deodorants					
Scented toiletries					
Cleaning agents					
Laundry detergents					
Pool chlorine					
Insecticide sprays					
Cigarette smoke					
Petrol					
Car fumes					
Other *(specify below)*					

Name _____ **Date**_____

13. Are you currently taking any medications or supplements? **Yes** **No**

If **yes**, please list below, including the name, brand, strength and how many you take per day/ week.

Medication				
Name (as on the label)	Brand (as on the label)	Medicine strength (as on the label)	How many do you take a day?	How many days per week do you take this medicine?
Supplement				
Name (as on the label)	Brand (as on the label)	Supplement strength (as on the label)	How many do you take a day?	How many days per week do you take this supplement?

14. Do you have any other comments you would like to add?

Name _____ Date_____

DIET HISTORY

Record the **CURRENT TYPICAL MEALS, FOODS, AND DRINKS** you eat.
Don't forget to include items such as stocks, sauces, herbs, spices, butter, margarine, and sugar.

Breakfast

Morning Tea

Lunch

Afternoon Tea

Dinner

Supper

Height (cm) **Weight (kg)**

Commonly eaten FRUIT (list)

Commonly eaten VEGETABLES (list)

CHECKLIST	
FOOD / DRINK	**TYPE & FREQUENCY**
Example: Soft drink	*Lemonade 1 x per week*
Water	
Tea (normal / decaf / herbal)	
Coffee (regular / decaf)	
Cow's milk / Soy or Rice Drink	
Juice	
Cordial	
Soft drink	
Alcohol	
Other drinks e.g., sports/ protein / energy drinks, breakfast drinks, etc.	
Cheese	
Yoghurt	
Crackers / Crispbreads	
Cake / Biscuits	
Chocolate	
Nuts / seeds	
Lollies	
Chewing gum / mints	
Crisps / Chips	
Dried fruit	
Sandwich fillings e.g., spreads, meats, etc.	
Spice, stock cube, sauces	
Oil (specify)	
Margarine (specify)	
Eating out / Takeaway	

-Thank you-