Health
Sydney
Local Health District
NSW GOVERNMENT

RPAH Allergy Unit

Name _____ **Date** _____

Date of birth _____ Age (yrs) _____

Height (cm) _____ Weight (kg) _____

DIET SYMPTOM QUESTIONNAIRE

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

1. Please indicate the symptoms you have <u>CURRENTLY</u> (in the last 6 months)?

SYMPTOM	FREQUENCY					SEVERITY				
	Never	Occas.	Monthly	Weekly	Daily	Mild		Mod.		Severe
EXAMPLE SYMPTOM	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐
SKIN										
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Swellings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rashes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
RESPIRATORY										
Hayfever (seasonal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Runny nose	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blocked nose	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Post nasal mucus drip	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Throat irritation/cough	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GASTROINTESTINAL										
Mouth ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reflux (acid)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heartburn	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Indigestion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Wind/Gas	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bloating/Discomfort	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stomach pain/cramps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diarrhoea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Variable bowel pattern	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CNS										
Headache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle/Joint aches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
GENITOURINARY										
Bladder irritation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vaginal irritation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify)										
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Name _____ Date _____

2. Indicate the OVERALL severity of your symptoms in the last 6 months ☐ **Mild** ☐ **Moderate** ☐ **Severe**

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

4. Do you have any of the following?

	Current	Past	Never	Details
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
Anorexia nervosa	☐	☐	☐	
Bulimia	☐	☐	☐	
Major loss of weight	☐	☐	☐	
Diabetes	☐	☐	☐	
Coeliac disease	☐	☐	☐	
Crohn's disease/Ulcerative colitis	☐	☐	☐	
Thyroid disease	☐	☐	☐	

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

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

If **yes**, please specify: _____

7. 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				
☐ Wheat-free diet				
☐ Milk-free diet				
☐ Lactose-free diet				
☐ Low-FODMAP diet				
☐ Other "Elimination" diet Specify: _____				
☐ Detox				
☐ Vegetarian/Vegan				
☐ Belief based diet (Kosher, ☐ Halal, Hindu etc.)				
☐ Mediterranean diet				
☐ Low cholesterol/low fat				
☐ Low calorie				
☐ Diabetic diet				
Other diets (specify)				

Name _____ **Date** _____

8. 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** _____

9. 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	☐	☐	☐	

10. 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)*	☐	☐	☐	☐	
	☐	☐	☐	☐	

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

If **yes**, please list below, including the name and brand:

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

Name _____ **Date** _____

DIET HISTORY

Record the **CURRENT TYPICAL MEALS, FOODS, AND DRINKS** you (your child) 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-