

Food Allergy Questionnaire

1. Personal Information

- Name: _____
- Age: _____
- Contact Information: _____

2. Symptoms and History

- Have you experienced any of the following symptoms after eating specific foods?
 - Hives
 - Swelling
 - Digestive issues
 - Breathing difficulty
 - Other (please specify): _____
- How long after eating do symptoms appear?
 - Immediately
 - Within an hour
 - Several hours later

3. Known Allergies

- Do you have known food allergies?
 - Yes (please specify): _____
 - No
- Are you allergic to any of the following common allergens?
 - Dairy
 - Gluten
 - Peanuts
 - Tree nuts
 - Shellfish

- Soy
- Eggs
- Other: _____

4. Food Testing

- Have you undergone allergy testing?
 - Yes (please provide results): _____
 - No

5. Additional Information

- Please provide any other relevant details about your food allergies:
