Food Allergy Screening Questionnaire

Full Name

Date of Birth

Email

1. Have you ever experienced any allergic reaction after eating certain foods?

- ○ Yes
- ○ No

2. List any foods you suspect cause a reaction:

3. What symptoms did you experience? (Check all that apply)

- ☐ Skin rash/hives
- ☐ Swelling (lips, face, throat, etc.)
- ☐ Difficulty breathing
- ☐ Nausea/vomiting/diarrhea
- ☐ Other

If "Other", please specify:

4. How soon after eating the food did the symptoms appear?

- ○ Immediately
- ○ Within minutes
- ○ Within an hour
- ○ Other

If "Other", please specify:

5. Have you ever needed emergency medical attention due to a food reaction?

- ○ Yes
- ○ No

If yes, please describe what happened:

6. Do you have a diagnosed food allergy?

- ○ Yes
- ○ No

If yes, by whom?

7. Please provide any additional information relevant to your food allergies: