Food Allergy Assessment Questionnaire

Personal Information

Full Name

Age

Email

Allergy Assessment

Do you have any known food allergies?

- Yes
- No

If yes, which foods are you allergic to? (List all)

What symptoms do you experience after consuming these foods?

How soon after eating do symptoms appear?

How severe are your reactions?

Have you ever received medical treatment for your reaction?

- Yes
- No

Family & Medical History

Does anyone in your family have food allergies?

- Yes
- No

Do you have any other allergies or medical conditions?

Additional Information

Any other relevant information you'd like to share?