KEYSTONE wellness

Comprehensive Allergy and Sensitivity Questionnaire

NAME_____________________________ **DATE**_______

This survey is designed to assess the signs and symptoms of allergies and sensitivities to foods, chemicals, inhalants and other allergens. Please mark the appropriate response for each question. Unless otherwise indicated, base your response on the past 30 days.

1. How varied is your diet? Circle foods from each of the following groups that you eat on a daily basis..

Fruits	Whole Grains	Vegetables
Leafy Greens	Eggs	Chicken
Dairy	Beans/Legumes	Fish/Seafood
Nuts/Seeds	Vegetables	Tofu/Soy products
Red meat		

Other:____

2. What type of bread do you most often eat?

White	Sourdough
Pumpernickel	Rye
Spelt	Whole wheat

Other:____

3. On an average day, how many servings do you have of:

Fruits______________________ Vegetables________________

4. How many times per week do you eat at a fast food restaurant? _________

5. How many alcohol beverages do you have a week? _________________

6. What do you usually put on toast? ______________________________

7. What dressing do you put on salads? ____________________________

8. Circle if you have reactions to any of the following?

MSG SUGAR FRUITS

ARTIFICIAL SWEETENERFOOD PRESERVATIVES