

Food Allergies: Self-Assessment Questionnaire

Childhood Symptoms

		Yes	No
1.	As an infant, did you have any problems tolerating formula or breast milk?	Y	N
2.	Did you have problems with gaining weight, colic, or spitting up during infancy?	Y	N
3.	As an infant, did you suffer from respiratory or skin problems?	Y	N
4.	Were you “difficult” in infancy and/or childhood, often crying or irritable, overactive or underactive?	Y	N
5.	Did you have problems sleeping or trouble learning or paying attention at school?	Y	N
6.	As a child, were you often sick, plagued by ear infections, sore throats, swollen glands, colds, bronchitis, croup, stomachaches, constipation, diarrhea, or headaches?	Y	N

Physical Symptoms

1.	As an adult, are you always tired, even though you get enough sleep?	Y	N
2.	Do you frequently have puffy eyes, wrinkles around the eyes, or dark circles under your eyes?	Y	N
3.	Itchy, red, watery, burning, painful, or light sensitive eyes?	Y	N
4.	Blurred vision?	Y	N
5.	Baggy, swollen eyelids?	Y	N
6.	Do you often have a stuffy, watery, runny nose?	Y	N
7.	Do you sneeze several times in a row?	Y	N
8.	Do you rub your nose upward or wiggle it?	Y	N