Dakota Allergy & Asthma

INTERNAL USE ONLY

Patient Name _____

Chart/Account # _____ DOB _____

Doctor _____

Date _____

FOOD ALLERGY QUESTIONAIRE

Please use ONE FORM PER FOOD

Name of Food?_____

When Did You Eat It Last and Reacted?_____

Primary Physician _____

How Much Food Was Eaten?_____

What Was the Reaction?_____

_____

How Many Minutes or Hours After Eating Did the Reaction Start?_____

How Long Did the Reaction Last?_____

How Did You Treat/Manage the Reaction? _____

_____

_____

How Many Times Have You Had the Reaction? _____

Did You Go To the ER? _____

Did You Try the Same Food Again? _____

Which Foods Are You Currently Strictly Avoiding?_____

_____

Do You Have Epi-Pen or Auvi-Q? _____

Do You Have an Anaphylaxis Action Plan? _____

What Are The Goals of Your Visit Today?_____

_____

_____

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