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? ______________________________

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

How Long Did the Reaction Last?______________________________

How Did You Treat/Manage the Reaction? ______________________________

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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?______________________________

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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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