Food allergy questionnaire: adults

For adults and teenagers who have reacted to a food.

Please type your answers into this form (or print and fill it in), save it, and email it to **referrals@vidamedical.com.au** at least **7 days before your appointment**. Skip anything that doesn't apply. If you are completing this for a child, answer for the child.

About you

Full name

Date of birth

Today's date

Phone and email

Completed by (if not the patient)

Usual GP and clinic

Your reactions

Use one column per reaction. Start with the most recent and the worst one.

Question	Reaction 1	Reaction 2	Reaction 3
Food or trigger you suspect			
Raw, cooked, baked or packaged?			
How much was eaten or touched?			
Date or age at the time			
First time having it?			
Time until symptoms started			
What happened? (in order)			
How long did it last?			
Treatment given (EpiPen, antihistamine, none)			
Ambulance, ED or hospital?			
Anything else at the time? (exercise, alcohol, ibuprofen, unwell)			
Had it again since? What happened?			
Happens every time?			

Symptoms you have had

- ☐ Hives
- ☐ Vomiting
- ☐ Wheeze or hard to breathe
- ☐ Collapsed
- ☐ Swelling of lips, eyes or face
- ☐ Stomach pain
- ☐ Tight throat or hoarse voice
- ☐ Food getting stuck when swallowing
- ☐ Itchy mouth or throat
- ☐ Diarrhoea
- ☐ Dizzy or faint
- ☐ Itchy mouth with raw fruit or vegetables only

Your diet

Foods you avoid, and why

Food	Eat it without problems?	Avoid it?	Never tried
Peanut			
Tree nuts (e.g. cashew, almond, walnut)			
Egg			
Milk			
Wheat			
Soy			
Sesame			
Fish			
Prawns, crab or lobster			
Other shellfish			
Red meat			

Other factors

Have you had a reaction only when you exercised after eating? ☐ Yes ☐ No ☐ Unsure

Do you get hay fever with an itchy mouth to raw fruit, vegetables or nuts? ☐ Yes ☐ No ☐ Unsure

Have you had tick bites, or reactions several hours after eating red meat? ☐ Yes ☐ No ☐ Unsure

Your job, and any food you handle at work

Do you have, or have you had:

☐ Eczema ☐ Asthma ☐ Hay fever
☐ Medicine allergy ☐ Latex allergy ☐ Previous anaphylaxis

Impact

How much does worry about food affect eating out, travel or social life?

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

Medicines

All medicines you take, including sprays, creams, vitamins and supplements

Do you take any of these?

- ☐ Antihistamines (e.g. Telfast, Zyrtec, Claratyne)
- ☐ Regular ibuprofen or aspirin
- ☐ Blood pressure or heart medicines
- ☐ Adrenaline autoinjector (EpiPen / Anapen)

Autoinjector expiry date (if you have one)

Family history

Does a parent, brother or sister have:

- ☐ Food allergy
- ☐ Hay fever
- ☐ Eczema
- ☐ Hives
- ☐ Asthma
- ☐ Not sure

Your goals

What would you most like to get out of this appointment?

Previous allergy tests (type, date, result). Please bring copies if available.

Before you arrive

Medicines: antihistamines and some other medicines can affect allergy testing. We'll email you instructions on which to pause and when. **Keep taking your asthma medicines.**

Bring: previous test results, photos of any reactions, and your adrenaline autoinjector if you have one.

Your information is confidential and stored in your medical record in line with our privacy policy.