Allergy Questionnaire

NAME:

ADDRESS:

HOME TEL: WORKS TEL

MOBILE:

D.O.B.

NAME OF PARENT (if applicable):

YOUR CURRENT PICTURE

GENERAL

Skin condition (please circle and add comments re frequency, triggers & location of outbreaks below)

Smooth Dry Oily Flaky Itchy
Eczema Psoriasis

Please circle the following wheat-based products you eat weekly:

Bread Pasta Biscuits
Cake Cous-Cous Pizza

Please circle the following dairy products you eat weekly:

Milk Cheese Butter
Cream Yoghurt

How many cans of soft drinks do you drink daily / weekly?

How many portions of sweets are eaten weekly?

Do you grind your teeth at night? Y /N

Do you dribble at night? Y /N

What is your concentration like? (please circle) Poor Fair Good Excellent

DIGESTIVE HABITS

Do you suffer from indigestion? Y /N

Do you know if you are intolerant to certain foods? Please list below Y /N

Do you have reflux problems? Y /N

Do you skip meals? If yes, which meal. Y /N

Do you eat after 8pm on a regular basis? Y /N

How many bowel movements do you have daily / weekly?

Do you suffer from Irritable Bowel Syndrome ? Y /N
(alternating diarrhoea and constipation). Describe triggers – if known

What best describes your stools? (please circle)
Light Medium Brown Dark
Sticky Pellets Well-Formed
Float Sink Smelly Explosive

How many times do you urinate at night?

Do you have problems with urination e.g. weak bladder? Y / N
(If yes, please state here)

How many times do you urinate daily?

What colour is your urine? (Please circle) Light Dark Orange Other

MEDICAL STATUS

GP NAME:

SURGERY NAME & ADDRESS:

SURGERY TEL.NO:

Are you currently on any medication? Y /N

If yes, please list their names and the condition they are for:

Do you have sinus problems ? (Add comments below) Y / N

Do you suffer with headaches? State frequency, location & triggers Y / N

Do you suffer with migraines? State frequency & triggers Y / N

Do you have verrucas? Y /N

Please list all vaccinations and age when given

Do you suffer from eczema or psoriasis? State frequency & triggers + location of where it is worse. Y /N

Do you have dandruff? Y /N

Do you suffer from piles? Y /N

Do you have a fungal infection on the feet or toes? Y / N

Do you take any supplements? If yes, please list below: Y /N

STRUCTURAL

Do you have any joint pain? If yes, which joints? Y /N

Do you have any muscle pain? If yes, which muscles? Y /N

Do you have arthritis? Y /N

Do you have rheumatism? Y / N

Do you have inflammation of joints or muscles? Y /N
If yes, please describe:

SIGNED………………………………………………………………. DATE……………………………..

PRINT NAME………………………………………………………

RELATIONSHIP TO CHILD (Where appropriate)……………………………………………………….