Food Reaction History:

Age at first reaction:	
What did you eat prior to the reaction?	
What food do you think caused the reaction?	
How much of the food was eaten?	
How long after eating did the reaction start?	
How did you treat the reaction?	
Number of times you reacted to this food:	
When was your last reaction to this food?	
Did you go to the Emergency Room (ER)?	
How long did the reaction last?	
Do you have an EpiPen / Auvi-Q / Adrenaclick	
Which foods are you avoiding now?	
Do you have a food allergy action plan?	
Have you had food allergy testing (skin or blood)?	

Fill out the sections that address the reaction you experienced:

YES	NO	Symptoms	YES	NO	Symptoms
□	□	Hives / Rash	□	□	Bloating
□	□	Nausea	□	□	Chest pain
□	□	Vomiting	□	□	Burning
□	□	Diarrhea	□	□	Throat swelling
□	□	Constipation	□	□	Throat tightness
□	□	Abdominal pain	□	□	Difficulty breathing in/out
□	□	Nasal symptoms	□	□	Dizziness
□	□	Lightheadedness	□	□	Near passing out / passing out

Allina Health **ALLERGY FOOD REACTION QUESTIONNAIRE**

Patient Name:_____
DOB:_____
Today's Date:_____