

DIET SYMPTOM QUESTIONNAIRE

1. Please indicate your current symptoms (in the last few months)

Symptom	Frequency				Severity		
	Never	Monthly	Weekly	Daily	Mild	Moderate	Severe
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny/blocked nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat irritation/cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive wind/gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Variable bowel patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/joint aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder irritation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital irritation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you have any of the following?

	Current	Past	Never	Comments
High stress levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anorexia Nervosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bulimia Nervosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Major weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Do you currently have any other medical conditions?

4. Please list any medications or supplements you currently take:

5. Do smells, fumes or environmental chemicals make you feel unwell?

E.g. perfumes, cleaning agents, pool chlorine, petrol, car fumes.

- Not at all A little A lot

6. Have you ever modified or restricted your diet? If yes, please explain:

Modification/restriction	Year modified	Reason for modifying	Source of advice (e.g. doctor, dietitian, naturopath, friend, family, internet, books)	Did it help? (comment)
<input type="checkbox"/> Vegetarian/Vegan				
<input type="checkbox"/> Belief based diet (Kosher, Halal, Hindu etc.)				
<input type="checkbox"/> Mediterranean diet				
<input type="checkbox"/> Low fat				
<input type="checkbox"/> Low calorie/low energy				
<input type="checkbox"/> Low carbohydrate				
<input type="checkbox"/> Gluten free diet				
<input type="checkbox"/> Wheat free diet				
<input type="checkbox"/> Milk free diet				
<input type="checkbox"/> Lactose free diet				
<input type="checkbox"/> Low FODMAP diet				
<input type="checkbox"/> An "Elimination" diet				
<input type="checkbox"/> Other (specify):				

7. Do you currently avoid any particular foods or drinks?

Food/drink	Symptoms of the worst reaction

8. What is your response to the following foods?

	OK	Dislike	Never Eat	React (please explain)
Cabbage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Garlic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Onion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Leek	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Legumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

9. At present, how much do your symptoms impact your quality of life?

- Not at all A little A lot

10. Do you have any other comments you would like to add?

Please record the current typical foods, meals and drink you consume, including spreads, sauces, spices, stocks, sugar.

	Check list	How much, how often?
Breakfast	Water	
	Tea	
	Coffee	
	Milk (cows, soy, almond, rice)	
	Juice	
Morning snack	Cordial	
	Soft drink	
	Alcohol	
Lunch	Other drinks (shakes, sports, energy drinks etc.)	
	Cheese	
	Yogurt	
	Crackers	
	Biscuits/cakes	
Afternoon snack	Chocolate	
	Nuts/seeds	
	Lollies	
	Chewing gum/mints	
Dinner	Chips/crisps	
	Dried Fruit	
	Sandwich fillings (spreads, meats etc.)	
	Commonly eaten fruit	
	Commonly eaten vegetables	
Evening snack	Spices, stock cubes, sauces	
	Oil (specify)	
	Butter/Margarine	