Santa Fe Center for Allergy & Environmental Medicine

Dietary History

Name: _____ Date: _____

Are you on any special type of diet (pure vegetarian, lacto-ovo vegetarian, kosher, etc.)?

1. List all foods and beverages which have ever caused any significant allergic reaction (e.g. hives, trouble breathing, severe problems, etc.), and the type of reaction.

2. List any foods or beverages which have caused *any adverse reaction* at all when you've eaten it (e.g. gas, constipation, diarrhea, heartburn, bloating, etc.)

3. List all foods or beverages which you now avoid or strictly limit because of the above reactions

4. List your *favorite, craved* or particularly enjoyed foods and beverages

5. List foods or beverages consumed at least twice daily

6. List foods or beverages consumed at least once daily (other than the above)

7. List as many foods as you can think of eaten in the past week