



If you have one or more of these symptoms, there's a 95% probability you'll benefit from a food sensitivity test.

Please place a check mark at each of your symptoms and return the completed checklist to your physician. Be sure to include symptoms that you've 'learned to live with'.

Digestive Tract

- Belching
- Bloating feeling
- Constipation
- Diarrhea
- Nausea
- Passing gas
- Stomach pains
- Vomiting

Ears

- Drainage from ear
- Ear aches
- Ear infections
- Hearing loss
- Itchy ears
- Ringing in ears

Emotions

- Aggressiveness
- Anxiety/fear
- Depression
- Irritability/anger
- Mood swings
- Nervousness

Energy & Activity

- Apathy
- Fatigue
- Hyperactivity
- Lethargy
- Restlessness
- Sluggishness

Eyes

- Blurred vision
- Dark circles

- Itchy eyes
- Sticky eyelids
- Swollen eyelids
- Watery eyes

Head

- Dizziness
- Faintness
- Headaches
- Insomnia
- Lightheadedness

Joint & Muscles

- Aches in muscles
- Arthritis
- Feeling of weakness
- Limited movement
- Pain in joints
- Stiffness

Lungs

- Asthma/bronchitis
- Chest congestion
- Difficulty breathing
- Shortness of breath
- Wheezing

Mind

- Confusion
- Learning disabilities
- Poor concentration
- Poor memory
- Stuttering/stammering

Mouth & Throat

- Canker sores
- Chronic coughing
- Gagging

- Often clear throat
- Sore throat
- Swollen tongue/lips/gums

Nose

- Excessive mucous
- Hay fever
- Sinus problems
- Sneezing attacks
- Stuffy nose

Skin

- Acne
- Dermatitis
- Eczema
- Excessive sweating
- Flushing/hot flashes
- Hair loss
- Hives/rashes
- Itching

Weight

- Binge eating
- Compulsive eating
- Cravings
- Excessive weight
- Underweight
- Water retention

Other

- Anaphylactic reactions
- Chest pains
- Frequent illness
- Genital itch
- Irregular heartbeat
- Rapid heartbeat
- Urgent urination

Patient's Name: _____ Phone #: _____

Address: _____

Weight _____ Height _____

During the last 30 days, have the symptoms you noted on the previous page...

1. Prevented you from getting a good night's sleep? Yes No

If yes, which symptoms? _____

How many nights? _____

2. Affected your performance at your place of employment? Yes No

If yes, which symptoms? _____

How many days? _____

3. Caused you to call in sick to your place of employment? Yes No

If yes, which symptoms? _____

How many days? _____

4. Caused you to leave your place of employment early? Yes No

If yes, which symptoms? _____

How many times? _____

Do you or anyone in your family have a history of allergies? Yes No

Have you or has anyone in your family ever been to an allergist or been tested for allergies?

Yes No

Do you have allergic reactions within 15 minutes or sooner after exposure to particular topical, ingested or inhaled substances such as:

- | | | |
|---|---|---|
| <input type="checkbox"/> Animal danders | <input type="checkbox"/> Iodine | <input type="checkbox"/> Plants or trees |
| <input type="checkbox"/> Cosmetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Shampoos and soaps |
| <input type="checkbox"/> Dust, pollen or mold | <input type="checkbox"/> Laundry detergents | <input type="checkbox"/> Skin creams |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medicines | <input type="checkbox"/> Sulfur |
| <input type="checkbox"/> Insect stings | <input type="checkbox"/> Penicillin | |

If so, can you identify the particular offending substance?

Do you have severe, dramatic allergic reactions (anaphylaxis) with skin reactions, swelling, respiratory distress, and/or low blood pressure?

If so, what causes it? (eg., bee stings, penicillin, etc.)