



Facility: ROYAL PRINCE ALFRED HOSPITAL

**DIET SYMPTOM  
QUESTIONNAIRE**

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date	You (or your child's) details			
	Height (cm)		Weight (kg)	

Please indicate the main reason(s) for this appointment?

Please indicate any symptoms you (or your child) have CURRENTLY (in the last 6 months)

Symptom	Frequency (Pick one)					Severity (Pick one)		
	Never	Occas.	Monthly	Weekly	Daily	Mild	Mod.	Severe
<b>Stomach</b>								
Nausea	<input type="checkbox"/>	<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"/>	<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"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bowel</b>								
Bloating/Discomfort	<input type="checkbox"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>
Variable Bowel Pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wind/Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Swallowing</b>								
Swallowing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin</b>								
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swellings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Rash/Itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anaphylaxis</b>								
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BINDING MARGIN - NO WRITING

DIET SYMPTOM QUESTIONNAIRE

MR 070.011

This questionnaire was completed by:

Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

05082025



# Sydney Local Health District

Facility: ROYAL PRINCE ALFRED HOSPITAL

## DIET SYMPTOM QUESTIONNAIRE

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____		M.O.
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Please indicate any symptoms you (or your child) have CURRENTLY (in the last 6 months)

Symptom	Frequency (Pick one)					Severity (Pick one)		
	<i>Never</i>	<i>Occas.</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily</i>	<i>Mild</i>	<i>Mod.</i>	<i>Severe</i>
Respiratory								
Hay Fever / Sinus Trouble	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Running Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blocked Nose / Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Nasal Mucus Drip	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Wheeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat								
Sore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tight/Swollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarse Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological								
Headache / Migraine	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Muscle / Joint Aches and Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal								
Pre-Menstrual Syndrome (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular / Painful Periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovary Syndrome (PCOS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BINDING MARGIN - NO WRITING

This questionnaire was completed by:

Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Sydney Local Health District

Facility: ROYAL PRINCE ALFRED HOSPITAL

## DIET SYMPTOM QUESTIONNAIRE

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Symptom	Frequency ( <i>Pick one</i> )					Severity ( <i>Pick one</i> )		
	Never	Occas.	Monthly	Weekly	Daily	Mild	Mod.	Severe
Other								
Mouth Ulcers	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Vulva / Vaginal Irritation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Irregularity / Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicate the overall severity of your (or your child's) symptoms in the last week

Mild                       Moderate                       Severe

At present, how much do your (or your child's) symptoms impact on your (their) quality of life?

Not at all                       Just a little                       Pretty Much                       Very Much

Do you (or your child) have any of the following?	Never	Past	Current	Details
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Major Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coeliac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crohn's Disease / Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eosinophilic Oesophagitis (EoE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tick Bite Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

This questionnaire was completed by:  
 Name (*please print*): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

BINDING MARGIN - NO WRITING

05082025

DIET SYMPTOM QUESTIONNAIRE

MR 070.011



**Sydney  
Local Health District**

Facility: ROYAL PRINCE ALFRED HOSPITAL

**DIET SYMPTOM  
QUESTIONNAIRE**

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Are you currently pregnant?

No                       Yes

Do you (or your child) have any other medical conditions? If yes, specify below.

No                       Yes

.....

.....

.....

.....

Do you (or your child) have any drug allergies?

Drugs	No	Yes	If yes, specify drug and please list symptoms
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	
Nurofen	<input type="checkbox"/>	<input type="checkbox"/>	
Other anti-inflammatory drug (specify if known)	<input type="checkbox"/>	<input type="checkbox"/>	
Antibiotic (specify if known)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	

BINDING MARGIN - NO WRITING

This questionnaire was completed by:

Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Sydney Local Health District

Facility: ROYAL PRINCE ALFRED HOSPITAL

## DIET SYMPTOM QUESTIONNAIRE

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Do you (or your child) have any food allergies? (Confirmed by a skin prick test (SPT) or blood test)  
Complete only those that apply.

Foods	Allergies		If yes, specify symptoms provoked by the food	Timing of reactions		Currently avoiding completely	
	No	Yes		Immediate < 2 hrs	Delayed > 2 hrs	No	Yes
Egg	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheat	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sesame	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peanut	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walnut	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hazelnut	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cashew	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Almond	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macadamia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brazil	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pine Nut	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pecan	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pistachio	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kiwi	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cod	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuna	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salmon	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mussel	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prawn	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crab	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lobster	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squid	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calamari	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red Meat	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BINDING MARGIN - NO WRITING

DIET SYMPTOM QUESTIONNAIRE

MR 070.011

This questionnaire was completed by:

Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Sydney  
Local Health District**

Facility: ROYAL PRINCE ALFRED HOSPITAL

**DIET SYMPTOM  
QUESTIONNAIRE**

SURNAME		MRN
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Do you (or your child) have any other allergies? (Confirmed by a skin prick test (SPT) or blood test)

Other allergies	No	Yes	If yes, specify symptoms provoked by other allergies
Dust Mite	<input type="checkbox"/>	<input type="checkbox"/>	
Grasses	<input type="checkbox"/>	<input type="checkbox"/>	
Pollen	<input type="checkbox"/>	<input type="checkbox"/>	
Mould	<input type="checkbox"/>	<input type="checkbox"/>	
Tick	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have an Adrenalin autoinjector (e.g. Epipen/Anapen) known allergies?

No                       Yes

Have you (or your child) modified or restricted your (their) diet? *Complete only those that apply.*

Modification/ Restriction	Year Modified	Reason for Modifying	Source of advice E.g. doctor, dietitian, friend/family, Internet/book	Did it help? E.g. not at all, just a little, pretty much, very much
Gluten-free diet				
Wheat-free diet				
Milk-free diet				
Lactose-free diet				
Low-FODMAP diet				
Other "Elimination" diet. Please specify.				
Detox				
Vegetarian/Vegan				
Belief based diet (Kosher, Halal etc.)				
Mediterranean diet				
Low cholesterol/low fat				
Low calorie				
Diabetic diet				
Other (specify)				

BINDING MARGIN - NO WRITING

This questionnaire was completed by:

Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Reviewing Form: \_\_\_\_\_ Signature: \_\_\_\_\_

Designation: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ : \_\_\_\_\_