



Allergy Questionnaire

Read each question carefully, and record the number next to a question if it applies to you. When you finish, add up the numbers you have recorded.

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|---|---|
| Do you experience fatigue? | 3 |
| Do you have frequent headaches? | 3 |
| Do you experience sneezing, persistent runny or itchy nose? | 4 |
| Do you have frequent colds? | 2 |
| Do you experience dizziness? | 4 |
| Do you suffer from yearly sinus infections? | 3 |
| Do your eyes itch, water, get red or swell? | 4 |
| Do you have recurrent ear infections? | 2 |
| Do you have asthma, wheezing or chronic cough? | 4 |
| Do you have eczema, itchy skin, or hives? | 3 |
| Do you have indigestion, bloating, diarrhoea or constipation? | 1 |
| Do your symptoms worsen during a particular season? | 4 |
| Do your symptoms change when you go inside or outside? | 3 |
| Are your symptoms worse in parks or grassy areas? | 4 |
| Are your symptoms worse in your bedroom after going to bed? | 2 |
| Do you wake in the middle of the night with a blocked nose? | 2 |
| Are your symptoms worse in dusty areas? | 4 |

Are your symptoms worse around animals?	2
Do you have any relatives with allergies?	2
Do you have mood swings or feel depressed for no reason?	1
Do you have recurrent yeast or fungal infections?	2
Do you develop symptoms after eating certain foods?	2
Do you sometimes feel stimulated or fatigued after meals?	2
Do you have dark circles under your eyes?	2
Do you have a crease across the bridge of your nose?	2
TOTAL SCORE	_____

< 9 allergies are unlikely

9-12 allergies are possible

13-30 allergies are probable

> 30 allergies very likely