

## QUESTIONNAIRE FOR SCREENING ADVERSE REACTIONS TO FOODS

### Q2 – Full Questionnaire

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Code: \_\_\_\_\_

Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ years

Gender:  Male  Female

School: \_\_\_\_\_

Interviewee:  mother  father  other

#### 1. Does your child have any health problem or reaction with any food or drink?

Yes  No  Does not know

#### 2. Which food or drink triggers a reaction?

Milk..... Yes  No  Does not know

Egg..... Yes  No  Does not know

Wheat..... Yes  No  Does not know

Fish..... Yes  No  Does not know

Soya..... Yes  No  Does not know

Peanut..... Yes  No  Does not know

Shrimp..... Yes  No  Does not know

Other Shellfish... Yes  No  Does not know

Pork..... Yes  No  Does not know

Fresh fruit..... Yes, Which? \_\_\_\_\_  No  Does not know

Legumes..... Yes, Which? \_\_\_\_\_  No  Does not know

Other ..... Yes, Which? \_\_\_\_\_  No  Does not know

(In questions 3 to 15, ask about each food, if there is more than one suspected food)

#### 3. When your child had the reaction, was that the first time that he/she ate (or drank) that food? (Yes/no/does not know; state how old your child was when that reaction took place)

Suspected food	Age	1st ingestion	1st reaction	Does not know

**4. How long after having eaten the food did the reaction occur?** (Await spontaneous response and only read the options subsequently)

Suspected food	Up to 2 hours / (min)	More than 2 hours/ (H)	Biphasic	Does not know

**5. What type of reaction did your child have after having eaten / drunk that food/drink?**

(Await spontaneous response and only read the options subsequently)

Symptoms	Suspected food	Yes	No
Cough			
Sneezing bout			
Nasal congestion			
Shortness of breath			
Itchy mouth or throat			
Swelling of lips, mouth or throat			
Itchy eyes			
Swelling of eyelids			
Swelling of face, ears, hands or feet			
Itchy skin			
Red or hot skin			
Skin rash (macules and papules)			
Nausea or vomiting			
Diarrhoea			
Abdominal pain or cramps			
Abdominal bloating			
Blood in stools			
Constipation			
Headaches			
Dizziness or fainting			
Other? Which type? (Describe: Sweating, pallour, cyanosis, syncope, palpitations, low blood pressure)			

**6. How was the reaction triggered by the food/drink?**

Suspected food	Direct Contact (mucosal)	Inhalation	Ingestion	Does not know

**7. If your child smells that food or it touches his/her skin, does he/she have any reaction?**

(shortness of breath, nasal congestion, erythema, itch, urticarial rash, other)

Suspected food	Contact	Inhalation	Both	No reaction	Does not know

**8. Were factors such as physical exercise, ingestion of medication or any other, associated with the reactions to foods?**

Suspected food	Exercise	Drug (name?)	Other	No reaction	Does not know

**9. Did your child ever have itchy, swollen or tingling lips, mouth or throat after having eaten any other food? (open question, followed by asking about any fresh fruit or legumes)**

Suspected food	Yes (describe symptoms)	No	Does not know

**10. Was your child taken to hospital when he/she had the reaction to food / drink?**

Suspected food	No	Yes, to casualty department; same day	Yes, on a different day	Does not know

**11. Did your child have to be given any medication when he/she had the reaction?**

Suspected food	No	Adrenaline	Corticosteroid	Bronchodilatador	Antihistamine	Does not know

**12. How long ago did the last reaction take place?**

Suspected food	< 1 Month ago	1 month – 1 year ago	1-5 years ago	> 5 years ago	Does not know

**13. After the first reaction, did your child eat the same suspect food again? Please describe the reaction, in case there was one.**

Suspected food	Yes			No	Does not know
	Same reaction	Other reaction (What type?)	No reaction		

**14. If your child ate the food more than once, have reactions to it changed in severity over time, to the same food?**

Suspected food	All reactions of same intensity	First reaction was the most severe one	Reactions have become more severe	Does not know

**15. In total, how many episodes of adverse reactions to the same food did your child have?**

Suspected food	1	2-5	>5	Does not know

**16. Does your child have any other allergies?**

	Yes	No	Does not know
Asthma			
Nasal allergies / rhinitis			
Cutaneous / atopic dermatitis			
Eye allergies /allergic conjunctivitis			
Other	Describe:		

**17. Does anyone in the child's family have any allergies?**

	Mother	Father	Brother / Sister
Food allergies			
Asthma			
Allergic rhinitis			
Allergic Conjunctivitis			
Atopic Dermatitis			