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)

Age / Suspected food	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)

Suspected food / **Symptoms**	**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			