Food and Chemical Sensitivity Survey

Date: __/__/____
Patient Name_____
Gender: M/F
Height: Feet ____Inches ____
Weight: _____lbs.
Please list all medications you are currently taking: _____

Please complete the following food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 60 days. This survey should be taken again after the completion of the Alcat Test, prior to reintroduction of "reactive" foods. Typically 3-6 months after initial testing. This comparison will help to assess the success of the eating modification program.

Symptom Scoring System:
•ooo = No Symptoms (*Zero Points*)
o•oo = Experience Mild Symptoms (*One Point*)
oo•o = Experience Moderate Symptoms (*Two Points*)
ooo• = Severe Symptoms (*Three Points*)

Digestive Symptoms
oooo Stomach Pains or Cramping
oooo Constipation
oooo Diarrhea
oooo Reflux or Heartburn
oooo Bloating
oooo Gas
oooo Nausea or Vomiting

Weight
oooo Inability to Lose Weight
oooo Food Cravings
oooo Binge Eating
oooo Water Retention

Sinus/Respiratory
oooo Stuffy or Runny Nose
oooo Asthma
oooo Chest Congestion
oooo Chronic Cough
oooo Wheezing
oooo Frequent Sneezing

Head/Ears
oooo Migraines
oooo Headaches
oooo Earaches
oooo Ear Infection
oooo Ringing in Ears

Eyes/Throat
oooo Itchy Eyes
oooo Watery Eyes
oooo Sore Throat
oooo Persistent Canker Sores

Emotional/Mental
oooo Depression
oooo Anxiety
oooo Mood Swings
oooo Irritability
oooo Poor Concentration

Energy
oooo Fatigue
oooo Hyperactivity
oooo Lethargy
oooo Restlessness
oooo Insomnia

Skin Disorders
oooo Eczema
oooo Dermatitis
oooo Excessive Sweating
oooo Rashes
oooo Hives

Other Symptoms:
oooo Joint Pain
oooo Arthritis
oooo Irregular Heartbeat
oooo Chest Pains
oooo Muscle Aches

Please list any symptoms not mentioned above:
_____
_____

Total Score: _____

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OAB-V8

Overactive Bladder-**Validated** 8-question Awareness Tool[1]

The questions below ask about how bothered you may be by some bladder symptoms. Some people are bothered by bladder symptoms and may not realize that there are treatments available for their symptoms. Please circle that number that best describes how much you have been bothered by each symptom. Add the numbers together for a total score and record the score in the box provided at the bottom.

How bothered have you been by...	Not at all	A little bit	Some-what	Quite a bit	A great deal	A very great deal
1. Frequent urination during the daytime hours?	0	1	2	3	4	5
2. An uncomfortable urge to urinate?	0	1	2	3	4	5
3. A sudden urge to urinate with little or no warning?	0	1	2	3	4	5
4. Accidental loss of small amounts of urine?	0	1	2	3	4	5
5. Nighttime urination?	0	1	2	3	4	5
6. Waking up at night because you had to urinate?	0	1	2	3	4	5
7. An uncontrollable urge to urinate?	0	1	2	3	4	5
8. Urine loss associated with a strong desire to urinate?	0	1	2	3	4	5
Are you a male?	If male, ☐ add 2 points to your score					

Please add up your responses to the questions above ☐☐

Please hand this page to your healthcare provider when you see him/her for your visit.

If your score is 8 or greater, you may have overactive bladder. There are effective treatments for this condition. You may want to talk with a healthcare professional about your symptoms.

Note: You may be asked to give a urine sample. Please ask before going to the bathroom.

Reference: 1. Coyne KS, Zyczynski T, Margolis MK, Elinoff V, Roberts RG. Validation of an overactive bladder awareness tool for use in a primary care setting. *Adv Ther.* In press.