Evans 4350 Towne Centre Dr
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Diet Journal

For Food Allergies and Intolerances

Instructions for Keeping a Food Diary

1. There are three types of diary sheets included:
   - **A.** The first is a symptom diary to be filled out before you start your avoidance diet. **(Before Diet Inventory)**
   - **B.** The second is a symptom diary to be filled out each day you are on the diet **(Elimination). You will need to make copies of this one for the days on the elimination diet.**
   - **C.** The third is a symptoms diary to be filled out when you reintroduce food **(Reintroduction Symptom Inventory)**

2. During the avoidance diet you need to keep careful track of your diet. Be specific about foods that you ate. You may identify other foods that you are sensitive to as you go through the process.

3. The Symptoms Diary lists common symptoms related to food allergies and intolerances. If you experience the symptoms then you need to rank how strong the symptom is. Rank how severe the symptoms is based on a scale of 1 to 10 with 1 being mild and 10 being severe. Circle the number.

4. Note all symptoms even if they seem mild. If you experience a symptom that is not listed then record it in the “Other” section.

5. If you have any chronic illnesses such as asthma, nasal allergies, bowel problems etc list these in the “Other” section and rank the severity each day.

6. If you experience immediate symptoms (within 30 minutes of eating a food) then record the symptoms in the immediate reaction column.

7. When challenge is complete, schedule follow up appointment with the doctor and bring your food diary.

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A

Diet Journal: Before

Day O: this is the day before you start the elimination diet. Eat your regular diet on this day.

Date: _____

Symptom Inventory	Rank
Respiratory	
Sneezing	1 2 3 4 5 6 7 8 9 10
Nasal congestion	1 2 3 4 5 6 7 8 9 10
Runny nose	1 2 3 4 5 6 7 8 9 10
Itchy or watery eyes	1 2 3 4 5 6 7 8 9 10
Cough	1 2 3 4 5 6 7 8 9 10
Wheezing	1 2 3 4 5 6 7 8 9 10
Digestive	
Nausea	1 2 3 4 5 6 7 8 9 10
Abdominal Pain	1 2 3 4 5 6 7 8 9 10
Bloating	1 2 3 4 5 6 7 8 9 10
Diarrhea	1 2 3 4 5 6 7 8 9 10
Constipation	1 2 3 4 5 6 7 8 9 10
Abdominal gas	1 2 3 4 5 6 7 8 9 10
Skin	
Hives	1 2 3 4 5 6 7 8 9 10
Eczema	1 2 3 4 5 6 7 8 9 10
Itch	1 2 3 4 5 6 7 8 9 10
Additional Symptoms	
Swelling of lips, mouth, face or tongue	1 2 3 4 5 6 7 8 9 10
Fatigue	1 2 3 4 5 6 7 8 9 10
Irritability	1 2 3 4 5 6 7 8 9 10
Poor appetite	1 2 3 4 5 6 7 8 9 10
Headache	1 2 3 4 5 6 7 8 9 10
Muscle/Joint pain	1 2 3 4 5 6 7 8 9 10
Canker sores	1 2 3 4 5 6 7 8 9 10
Other:	
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10

Food Diary		
Food eaten	**Time**	**Immediate Reaction**

Comments:_____

_____

_____

_____

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B _____

Diet Journal: Elimination

Day # (circle) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21

Follow strict elimination of the food from your diet. Read labels and avoid!

Date: _____

Symptom Inventory	Rank
Respiratory	
Sneezing	1 2 3 4 5 6 7 8 9 10
Nasal congestion	1 2 3 4 5 6 7 8 9 10
Runny nose	1 2 3 4 5 6 7 8 9 10
Itchy or watery eyes	1 2 3 4 5 6 7 8 9 10
Cough	1 2 3 4 5 6 7 8 9 10
Wheezing	1 2 3 4 5 6 7 8 9 10
Digestive	
Nausea	1 2 3 4 5 6 7 8 9 10
Abdominal Pain	1 2 3 4 5 6 7 8 9 10
Bloating	1 2 3 4 5 6 7 8 9 10
Diarrhea	1 2 3 4 5 6 7 8 9 10
Constipation	1 2 3 4 5 6 7 8 9 10
Abdominal gas	1 2 3 4 5 6 7 8 9 10
Skin	
Hives	1 2 3 4 5 6 7 8 9 10
Eczema	1 2 3 4 5 6 7 8 9 10
Itch	1 2 3 4 5 6 7 8 9 10
Additional Symptoms	
Swelling of lips, mouth, face or tongue	1 2 3 4 5 6 7 8 9 10
Fatigue	1 2 3 4 5 6 7 8 9 10
Irritability	1 2 3 4 5 6 7 8 9 10
Poor appetite	1 2 3 4 5 6 7 8 9 10
Headache	1 2 3 4 5 6 7 8 9 10
Muscle/Joint pain	1 2 3 4 5 6 7 8 9 10
Canker sores	1 2 3 4 5 6 7 8 9 10
Other:	
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10

Food Diary		
Food eaten	**Time**	**Immediate Reaction**

Comments:_____

_____

_____

_____

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C _____

Diet Journal: Challenge

Day # (circle): Challenge 1 Challenge 2 Challenge 3

Add the suspected food back into your diet today. If immediate symptoms develop, treat the reaction and remove food from the diet.

Date: _____

Symptom Inventory	Rank
Respiratory	
Sneezing	1 2 3 4 5 6 7 8 9 10
Nasal congestion	1 2 3 4 5 6 7 8 9 10
Runny nose	1 2 3 4 5 6 7 8 9 10
Itchy or watery eyes	1 2 3 4 5 6 7 8 9 10
Cough	1 2 3 4 5 6 7 8 9 10
Wheezing	1 2 3 4 5 6 7 8 9 10
Digestive	
Nausea	1 2 3 4 5 6 7 8 9 10
Abdominal Pain	1 2 3 4 5 6 7 8 9 10
Bloating	1 2 3 4 5 6 7 8 9 10
Diarrhea	1 2 3 4 5 6 7 8 9 10
Constipation	1 2 3 4 5 6 7 8 9 10
Abdominal gas	1 2 3 4 5 6 7 8 9 10
Skin	
Hives	1 2 3 4 5 6 7 8 9 10
Eczema	1 2 3 4 5 6 7 8 9 10
Itch	1 2 3 4 5 6 7 8 9 10
Additional Symptoms	
Swelling of lips, mouth, face or tongue	1 2 3 4 5 6 7 8 9 10
Fatigue	1 2 3 4 5 6 7 8 9 10
Irritability	1 2 3 4 5 6 7 8 9 10
Poor appetite	1 2 3 4 5 6 7 8 9 10
Headache	1 2 3 4 5 6 7 8 9 10
Muscle/Joint pain	1 2 3 4 5 6 7 8 9 10
Canker sores	1 2 3 4 5 6 7 8 9 10
Other:	
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10

Food Diary		
Food eaten	**Time**	**Immediate Reaction**

Comments:_____

_____

_____