Florida Allergy & Asthma Associates

Patient Questionnaire

Name____ Date____________________

Briefly, describe reason for your Allergy visit:

List all medications you are currently taking:

Medication	Dose	Frequency

Have you taken any other medications in the past, for the above conditions? If yes, please list:

Please list any other Medical Conditions:

Please list ALL previous **Hospitalizations:**

Approx. Date	Diagnosis or Procedure	Location

Are you Allergic to any Medications? YES NO

Please list the medication and the reaction:

Medication	Reaction

Family Medical History:

	Age(s)	Medical Condition(s)
Mother:		
Father:		
Sister(s):		
Brother(s):		