FLORIDA ALLERGY CLINICS
Specializing in Allergy & Asthma Care
for Children and Adults

1200 West State Road 434, Suite #112
Longwood, FL 32750
Office: 407-869-8747
Fax: 407-869-8108

Peter Ruggiero, M.D.

Patient Overview

Welcome to our office. Please take a few minutes to complete this form with as much detail as possible. Your responses will help the doctor to better serve your needs.

Name _____ Date ____ / ____ / ____

Allergy History:

1. Please describe the medical problem that you would like to discuss today

_____
_____
_____
_____

2. Do you have any of the following symptoms? (Circle all that apply)

Sniffles/Runny Nose	Itchy Nose/Eyes/Throat	Sneezing
Sinus Congestion	Post-Nasal Drainage	Stuffy Nose
Sinus Pressure	Nighttime Awakening	Chest Tightness
Bloody Nose	Difficult Breathing	Dry/Itchy Skin
Swelling	Sore Throat	Headache
Nasal Discharge	Fever	Rash
Cough	Wheezing	Hives

Decreased Exercise Capacity

3. Are any of these problems common in your immediate family? (Circle One)

Yes No

4. Do these symptoms occur throughout the year, or are they seasonal?

_____

5. Which seasons are most troublesome? (Circle all that apply)

Winter Spring Summer Fall

(Over)

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Patient Overview *(Continued)*

Allergy History:

6. Can you identify particular things, circumstances or situations that will cause or aggravate your problem?

_____

_____

_____

7. Have you ever been evaluated for allergies/asthma before? (Circle One)

Yes No

8. Have you taken allergy shots previously/present? (Circle One)

Yes No Please indicate approximate dates: _____

9. Are you allergic or sensitive to: (List specific Drugs/Foods)

I. Foods:

II. Drugs:

III. Pets:

IV. Stinging Insects:

10. Please list any other current/chronic medical conditions that you may have, that are being addressed by a physician.

_____

_____

_____

11. Please list all prescriptions that you use regularly.

_____

_____

_____