

DR. PETER (CHING SANG) LEE, M.D., F.R.C.P.C*

CLINICAL IMMUNOLOGY AND ALLERGY, INTERNAL MEDICINE

Date of Visit:		Preferred Name: <i>(if different from name on CareCard)</i>		
↓ Legal Name <i>(as it appears on your Care Card for billing)</i>				
Last:		First:	Middle:	
Date of Birth:		Health Care #:		
Mailing Address:		Biological Gender: M <input type="checkbox"/> F <input type="checkbox"/> <i>If you identify outside of your biological gender, please note:</i>		
Email Address:		M <input type="checkbox"/> F <input type="checkbox"/> Nonbinary <input type="checkbox"/>		
Primary Phone #: <i>Is this a cell phone?</i> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(automated reminder calls will go to this number)</i>		Secondary Phone #: Cell <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/>		
Legal Guardian(s): <i>(if patient is under the age of 19)</i>				
Name: _____		Relation _____	Phone #: _____	
Name: _____		Relation _____	Phone #: _____	
Referring Physician:		Family Physician:		
Main Concerns:				
Current Medical Illness: <i>(Please check off all that apply)</i>				
High Blood Pressure <input type="checkbox"/>	High Cholesterol <input type="checkbox"/>	Cancer <input type="checkbox"/>	Depression <input type="checkbox"/>	Anxiety <input type="checkbox"/>
Bipolar Disorder <input type="checkbox"/>	Hypothyroidism <input type="checkbox"/>	Sleep Apnea <input type="checkbox"/>	Deviated Septum <input type="checkbox"/>	GERD <input type="checkbox"/>
Asthma <input type="checkbox"/>	COPD <input type="checkbox"/>	Eczema <input type="checkbox"/>	Psoriasis <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Other:				
Current Medications: <i>(there is space for VITAMINS and SUPPLEMENTS on other side)</i>				

*****PLEASE TURN OVER THE PAGE AND COMPLETE THE OTHER SIDE*****

Vitamins and Supplements:

Known Allergies to Medications:

Other Known Allergies: *(this includes food, environmental, insects, contact allergies etc)*

Family History: *Please indicate which family member(s) it is for each condition checked off. This includes first- and second-degree blood relatives (parents, grandparents, siblings, children, aunts/uncles, cousins).*

Environmental Allergies _____

Food Allergies _____

Drug Allergies _____

Asthma _____

Eczema _____

Diabetes _____

Cancer _____

Heart Disease _____

Other:

Occupation:

Do you have pets at home? If yes, what kind?

If you smoke, how often and how much do you smoke?

Tobacco

Cannabis

If you drink, what is your average alcohol consumption per week:

Have you ever been stung by a wasp or bee before?

If yes, what kind of symptoms did you have?

Yes

No

Surgeries from the past 10 years: