

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

CLINICAL IMMUNOLOGY AND ALLERGY, INTERNAL MEDICINE

<b>Date of Visit:</b>		<b>Preferred Name:</b> <i>(if different from name on CareCard)</i>				
<b>↓ Legal Name</b> <i>(as it appears on your Care Card for billing)</i>						
Last:	First:	Middle:				
<b>Date of Birth:</b>		<b>Health Care #:</b>				
<b>Mailing Address:</b>		<b>Legal Sex on CareCard:</b> <input type="checkbox"/> M <input type="checkbox"/> F				
		<i>If you identify outside of your biological sex, please specify:</i> <input type="checkbox"/> M to F transgender <input type="checkbox"/> F to M transgender <input type="checkbox"/> Other:				
<b>Email Address:</b>						
<b>Primary Phone #:</b> <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>		<b>Secondary Phone #:</b> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/>				
<b>Legal Guardian(s):</b> <i>(if patient is under the age of 19)</i>						
Name: _____		Relation _____	Phone #: _____			
Name: _____		Relation _____	Phone #: _____			
<b>Referring Physician:</b>		<b>Family Physician:</b>				
<b>Main Concerns:</b>						
<b>Current Medical Illness:</b> <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"/>
<b>Other:</b>						
<b>Current Medications:</b> <i>(there is space for VITAMINS and SUPPLEMENTS on other side)</i>						

**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:**  
\_\_\_\_\_

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

**If yes, what kind of symptoms did you have?**

Yes

No

**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:**

**Surgeries (under general anesthetic) from the past 10 years:**