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

CLINICAL IMMUNOLOGY AND ALLERGY, INTERNAL MEDICINE

Date:		**Preferred Name:** *(if different from name on CareCard)*
Legal Name ⬇ *as it appears on your Care Card*		
Last:	**First:**	**Middle:**
Birth Date:	**Gender:**	**Health Care #:**

Mailing Address:

Primary Phone #: *(automated reminder calls will go to this number)*	**Secondary Phone #:**

Legal Guardian: *(if patient is under the age of 19)*

Name: ______________________________ **Phone #:** ____________________________________

Name: ______________________________ **Phone #:** ____________________________________

Referring Physician:	**Family Physician:**

Main Concerns:

Current Medical Illness: *(Please check off all that apply)*

High Blood Pressure ☐	**High Cholesterol** ☐	**Cancer** ☐	**Depression** ☐	**Anxiety** ☐
Bipolar Disorder ☐	**Hypothyroidism** ☐	**Sleep Apnea** ☐	**Deviated Septum** ☐	**GERD** ☐
Asthma ☐	**COPD** ☐	**Eczema** ☐	**Psoriasis** ☐	**Diabetes** ☐

Other:

Current Medications:

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: