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

CLINICAL IMMUNOLOGY AND ALLERGY, INTERNAL MEDICINE

| | |
|---|---|
| **Date of Visit:** | **Preferred Name:** *(if different from name on CareCard)* |
| ⬇ **Legal Name** *(as it appears on your Care Card for billing )* | |

| | | |
|---|---|---|
| **Last:** | **First:** | **Middle:** |

| | |
|---|---|
| **Date of Birth:** | **Health Care #:** |

| | |
|---|---|
| **Mailing Address:** | **Sex: M ☐ F ☐**<br>*If you identify outside of your biological sex, please specify:* |
| **Email Address:** | |

| | |
|---|---|
| **Primary Phone #:** ***Is this a cell phone?*** **Yes ☐ No ☐**<br>*(automated reminder calls will go to this number)* | **Secondary Phone #: Cell ☐ Work ☐ Other ☐** |

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

**Name: _____ Relation _____ Phone #: _____**

**Name: _____ Relation _____ 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:** *(there is space for VITAMINS and SUPPLEMENTS on other side)*

*****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:**