NAME _____ DATE:_____
DATE OF BIRTH _____ AGE _____ SEX: M___ F ___
FAMILY DOCTOR_____
WHO REFERRED YOU TO DR TSAI?_____
NEXT OF KIN (EMERGENCY CONTACT) _____
TEL _____

REASON FOR TODAY'S VISIT:
_____
_____

PAST MEDICAL HISTORY(PLEASE LIST OTHER MEDICAL PROBLEMS)_____
_____
_____

SMOKER: How many years? _____ How many packs per day?_____
NON-SMOKER: ____
EX-SMOKER : When did you quit?_____ How many years did you smoke:_____
How many packs per day?_____

CURRENT MEDICATIONS(INCLUDE VITAMINS, OVER THE COUNTER, HERBALS)_____
_____
_____

FAMILY HISTORY(DOES YOUR FAMILY ASTHMA, ALLERGIES OR ECZEMA?):
_____
_____

ENVIRONMENTAL HISTORY
House/Apt: Age of home:_____ How long have you lived there?:_____
Heating: Gas ____Electric____ Oil____Hot Water _____Wood Stove ____Other _____
Air Conditioning: Central_____ Window_____ None____
Pets: Dog _____ Cat _____ Other :_____
Air Filters: Hepa _____ Electronic _____ Other: _____ Bedroom
Flooring: Hardwood _____Carpet _____Area Rug _____Tile _____
How many people at home:_____ Smokers (how many?):_____
Problems with Mold or Mildew (where in home?):_____

MEDICATION COVERAGE:
Which of the following applies to you for medication coverage:
____ Ontario Drug Benefit (ODB)
____ Trillium Drug Program
____ Private insurance (ie SunLife, Great West, Etc)
____ None

Consent:

Patient Name: _____ Date of birth: _____

Parent/Guardian name (for minors under 16 years old): _____

* Our clinic works closely with the Kingston Allergy Research unit at KGH to help find patients suitable for potential allergy and asthma studies. Please indicate whether or not we can contact you to share information about potential studies. You may withdraw your consent at any time. We do not/will not sell/share your personal information.

____ Yes I give my consent ____ No I do not give my consent

Signature of patient/parent of minor: _____
Date: _____

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* I give Kingston Allergy and Asthma permission to leave a detailed message regarding blood work results/appointment information: ____ Yes ____ No

Signature of patient/parent of minor: _____
Date: _____

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* I understand that communication through Kingston Allergy and Asthma email (tsaiallergy@gmail.com) is not secure. If you choose to communicate with our office through e-mail, it is assumed that you are aware of the risks inherent in email communication and agree to the assumption of those risks.

Signature of patient/parent of minor: _____
Date: _____

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* For adults 16 years of age or older:

____ I give my consent for staff of Kingston Allergy and Asthma to communicate with the listed parent(s)/member of my family about: (please circle one or both): blood test results and/or appointment information:

family member name(s):
_____
_____

____ I do NOT give the staff of Kingston Allergy and Asthma permission to communicate any information about myself and/or appointment information to anyone.

Signature: _____
Date: _____