Allergy and Clinical Immunology

Patient Information

Date (yyyy-mm-dd): ____________ Date of Birth (yyyy-mm-dd): ____________

Surname	First name	Middle name

Home phone	Work phone	Cell phone	Email address

Place of employment	Type of work

School/College/University	Grade	Course

Civic no.	Street	City

Province	Country	Postal Code

Medical History

Current Medication (including any vitamins, naturopathic remedies, over the counter medication, oral contraceptives)

Medical Conditions (e.g. hypertension, diabetes, thyroid disorder)

Past Surgeries

Medication Allergies ○ Yes ○ No

Food Allergies ◯ Yes ◯ No

If yes, describe the reaction that occured with each medication

Have family members with allergies ◯ Yes ◯ No

If yes, list allergies with each family member

A reaction to insect sting (bee, wasp, hornet, ets.) ◯ Yes ◯ No

If yes, list

Environmental History (Present Conditions)

Residence

◯ House ◯ Town House ◯ Condo/Apartment ◯ Basement Suite ◯ Mobile Home ◯ Other

House

Age of House/Building ____ years. How long have you lived there ____

Mattress

◯ Futon ◯ Foam ◯ Box spring mattre Age of mattress ____ years

Pets

Type ____ Where kept? ____

Smoking

◯ none ◯ parent ◯ parents

others ____ where do they smoke? ◯ indoors ◯ outdoors

Previous Smoking

Stopped ____ years ago, smoked for ____ years ____ cigarettes per day

Alcohol

Drinks per week ____

Hobbies

House Plants ◯ 1-2 ◯ 3-5 ◯ 5-10 ◯ over 10