Dr Amanda Jagdis, MD, FRCPC, FAAAAI
Clinical Immunology & Allergy; Internal Medicine
212-1964 Fort St. Victoria BC V8R 6R3
Tel: 250-590-0559 Fax: 250-220-3339

Appointment Date	**NAME (as on Care Card)** **FIRST:** **MIDDLE:** **LAST:**	
CARE CARD#:	**Preferred name (***if different from above***)**	
DATE OF BIRTH:	**Gender**	**EMAIL (***for appointment reminders***)**
TELEPHONE NUMBER **Primary (***for appointment reminders***):** **Secondary:**	**MAILING ADDRESS** **Street:** **City:** **Postal Code:**	
PARENTS/LEGAL GUARDIANS (*if patient is under 19years*) **Name:** **Tel#:** **Name:** **Tel#:**	**Family doctor:** **Referring doctor:**	**PHARMACY (***if applicable***)**

MAIN CONCERN: *Please describe what has brought you to the clinic today and how you would like us to help.*	
PLEASE LIST YOUR MEDICAL HISTORY *(eg. high blood pressure, asthma, heart disease, depression, cancer etc.)*	
SURGERIES	
CURRENT MEDICATIONS (*include puffers, vitamins and supplements*)	
Please circle/complete as applicable	
Do you have an EpiPen? Yes / No If yes, what is the expiry date?______/______	If you drink alcohol: What is your average alcohol consumption per week?
Do you use either of the following: □ Tobacco □ Cannabis Average consumption:______________________ For how long? ______________________ Do others in the home environment smoke? Yes / No	Work/Occupation: Work location (office, outdoors, etc): Do you have extended health benefits? Yes / No

*****PLEASE TURN OVER AND COMPLETE PAGE 2*****

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PLEASE DESCRIBE OTHER KNOWN ALLERGIES (*list the trigger, reaction, and how long ago it occurred*)	
FOOD ALLERGY	
MEDICATION ALLERGY	
BEE/WASP STING ALLERGY	
LATEX	
OTHER	

HOME ENVIRONMENT: *(Please circle as applicable)*

Type of home	Apartment	Basement suite	Detached house	Mobile home	Townhome	Other
Approximate age of the building						
Are there carpets?	In the home	In the bedroom				
Type of heating	Baseboard	Forced air	Radiant	Other:		
Are there pets in the home?	Cat	Dog	Other:			

Height__________________Weight _____________

Consent for Electronic Communications

Dr. Jagdis may offer to communicate using the following means of electronic communication:
Telephone/videoconference
Email communication (for sending photos only)

I hereby acknowledge and agree to engage in electronic communication with my health care provider. I am comfortable to assume the risk of this communication. Assurance is offered from my care provider's office that every effort possible will be made to ensure both confidentiality and clinical accuracy.

I understand also that this consent can be withdrawn at any time.

Name:____

Date:____

Signature:____