Dr. Amanda Jagdis, M.D., F.R.C.P.C.
212-1964 Fort St, Victoria BC V8R 6R3
Phone: 250-590-0559 Fax: 250-220-3339

APPOINTMENT DATE: _____

NAME (as on Care Card): FIRST:_____MIDDLE:_____LAST:_____ Gender _____

DATE OF BIRTH: (day) _____(month) _____(year) _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

PHONE: _____WORK: _____CELL:_____

CARE CARD#: _____PHARMACY: _____

REFERRAL DR: _____ FAMILY DR: _____

If the patient is a child, list parents' names for contact purposes: _____

PLEASE DESCRIBE YOUR PENICILLIN ALLERGY (If known- what year, and what were the symptoms)

_____
_____
_____

PLEASE LIST YOUR MEDICAL HISTORY (ie high blood pressure, diabetes, depression/anxiety, cancer etc):

_____
_____
_____
_____

WHAT SURGERIES HAVE YOU HAD?:

_____
_____

WHAT MEDICATIONS DO YOU TAKE?:

_____
_____

DO YOU HAVE ANY OTHER ALLERGIES?:

_____

Do you smoke? no yes For how long? _____ years When did you quit? _____
Do you drink alcohol? no yes How many drinks per week? _____
Work/occupation: _____ Work location (office, outdoors, etc):_____

Height _____cm Weight _____ kg
