Ellie Tsai, MD, FRCPC
Royal College Certification in Clinical Immunology and Allergy
Asthma and Allergic Diseases
805 Blackburn Mews
Kingston, Ontario
(p)613-546-6673, (f)613-544-3288

PATIENT INFORMATION

Name: ____
Date of Birth: ________________________________ Age: __________ Sex: _______________________
Family Physician: ____
Who referred you to Dr. Tsai: ____
Next of KIN (Emerg. Contact) Name: __________________________________ Tel: _________________

PATIENT HISTORY

Reason for today's visit:
____
____

Past Medical History (Please list all medical problems):
____
____

Smoker:
(y/n): ________ If yes, how many years: ________ If yes, how many packs/day: __________________
Ex-Smoker:
When did you quit? ______________________ How many years did you smoke? _________________
How many packs/days? ___________________

Marijuana:
(y/n) ________ If yes, how years_______ If yes, how many times per/week? ___________

Vaping:
(y/n): _______ If yes, how times/day

Current Medications (Include vitamins, over the counter, herbal):
____
____

Family History (Does your family have asthma, allergies, or eczema?):
____
____

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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: _______ Other: _______

Pets:
Dog: _______ Cat: _______ Other: _________________________________

Air Filters:
Hepa: ______ Electronic: _______ Other: _______

Flooring:
Hardwood: ______ Carpet: _______ Area Rug: ______ Tile: _______

How many people live at home: _______ How many are smokers: _________

Problems with mold/mildew? Where in the home? _____________________________________

Insurance Coverage?
___ Ontario Drug Benefit (ODB) or OHIP +
___ Trillium Drug Program
___ Private Insurance (i.e. Sunlife, Great West Life) ______________________________
___ Military (Blue Cross)
___ None

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CONSENT

1)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 we can contact you to share information about potential studies. You may withdraw your consent at any time. We do not/will not share your personal information.

___ Yes, I give my consent ___ No I do not give my consent

Signature: ______________________________ Date: _____________________

2) I give Kingston Allergy and Asthma permission to leave a detailed message regarding blood results/ appointment information.

______ Yes, I give my consent ______ No I do not give my consent

Signature: ____________________________ Date: ______________________

3) 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: ____________________________ Date: ______________________

*****FOR ADULTS 16 YEARS OF AGE OR OLDER*****

*I give my consent for staff of Kingston Allergy and Asthma to communicate with the listed members of my family about the following:
_______ Blood Test Results _______ Appointment information

Name/ Relation ____

Signature: _______________________________________ Date: _______________________

*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: _______________________