Date: _____

Name _____ Birth date (month/day/year) _____

Address _____ City _____

Phone (Home) _____ (work, cell #) _____

Email _____ Family Doctor _____

Referring Doctor _____ Health Card # _____

Have you seen Drs. Gooderham/Freeman/Swales/ Nicholson/O'Toole/Kwan-Katipunan (please circle) in the past? When? _____ Reason for your visit today _____

Please List **ALL** medical conditions (past/present) Pharmacy_____

_____ _____ _____

_____ _____ _____

Please list all current medications

_____ _____ _____

_____ _____ _____

Are you on a blood thinner? (Aspirin, Plavix, Coumadin, other) Yes ____ No ____

Please list **all allergies** _____ _____ _____

_____ _____ _____ _____

Please list any allergies causing anaphylactic Shock (Food/Medication): _____

_____ _____ _____ _____

Do you use an Epi Pen? Yes ___ No ___ Do you currently have it with you? Yes___ No ____

Family History (please circle those conditions in any family members)

Melanoma Non-Melanoma skin cancer Other Cancer Thyroid Disease Stroke
Blood Clots Psoriasis Autoimmune Disorders Diabetes Bowel Disease
Arthritis Eczema

I have read and understand the 'Office Policies' (please sign Patient or Guardian)

_____