Dr. SHAVINDER GILL, Inc. M.BS, ABIM, ABSM, FRCP(C), FACP
DIPLOMATE OF AMERICAN BOARD OF INTERNAL MEDICINE

ALLERGY TESTING AND CARDIAC DISEASES

2415 Ware Street.
Abbotsford, BC

CONFIDENTIAL

ALLERGY PATIENT REGISTRATION FORM (Please write in Capital letters)

Full Name (Last, First): _____

Home Address: _____

City: ABBOTSFORD/ Home phone: _____

Occupation: (Present or Past) _____

Marital status: Married/Divorced/Widowed/Separated/Single.

Please circle YES or NO

Do you get itchy eyes/nose? : YES/NO

Do you get running eyes/nose? : YES/NO

Do you get sneezing? : YES/NO

Do you get nasal blockage or post-nasal discharge? : YES/NO

What is the color of nasal or post-nasal discharge? (Please circle one) Clear/ Yellow/ Green.

Do you get any of these symptoms? (Please circle) Cough/ Shortness of breath/ wheezing.

Do you get cough, SOB or Wheezing with exercise? : YES/NO

When are your symptoms worse? : Year around or certain seasons. Please circle one

If worse during certain months, please list: _____

Are your symptom worse indoor or outdoors or both? Please circle one.

Are your symptoms worse at work? : YES/NO

Do you get any of these symptoms during night? : YES/NO

For how long do you have these symptoms: _____

Have you tried any prescribed medication? : YES/NO

If yes which one? _____. Did it work: YES/NO

Are your symptoms getting worse now? : YES/NO/ Unchanged

Do you have carpet at home? YES/NO

What Kind of heating system do you have at your home? Please circle: Gas / Water / Oil

Do you have any pets? : YES/NO, if yes please list_____

Are you allergic to any animals? Yes/No if yes please list _____

Do you get any itching in mouth or throat after eating any fruits or any other food? Yes/No

Do you get hives? : YES/NO, if yes for how long_____

MORE QUESTIONS ON THE BACK OF THIS PAGE

Did you ever have a severe reaction to Bee, Wasp or any other insect sting? : YES/NO

Do you have family history of allergies, asthma or eczema? If yes please circle.

Do you get any problem when you wear or touch any metal? YES/NO

Do you have any food allergies? : YES/NO. If yes please list below with type of reaction.

FOOD	REACTION WHEN EAT
_____	_____
_____	_____

Are you allergic to any medication? : YES/NO

If yes then list them with type of reaction

DRUG	REACTION WHEN TAKE
_____	_____
_____	_____

Do you feel the white fluff in the air contributes to your symptoms? : YES/NO

Do you wish to participate in a study to see if your allergies are cottonwood related? : YES/NO

Please list all the medication in space below (Capital letters please):

1. 2. 3.

Smoking History: Do you smoke? : YES/NO

If yes, Cigarettes per day_____ How Long_____ Still smoking YES/NO

If no when did you quit _____

Do you drink alcohol? : YES/NO. If yes how much and how often_____

PLEASE LIST ANY OTHER HEALTH PROBLEMS. _____

I, the undersigned, being a patient of Dr. Shavinder Gill acknowledges that I have been informed the risk involved in the Allergy testing. This may involves hives (locally or whole body), swelling (locally or whole body), worsening of rhinitis and or asthma, and or systemic reaction.

Signature: _____ Date: _____

Read over and explained to the signatory and stated that the patient understood it an offered the signature in my presence.

_____

(Witness