WELCOME TO DR TIA LIU'S OFFICE

www.drtialiu.com

Surname_____First Name_____ Initial_____

Care Card number_____ Female _____ Male_____Preferred Pronoun_____

Age____ Date of Birth: Day_____Month_____Year_____ Occupation_____

Address_____ City_____PROV____ Postal Code_____

Phone_____ E-mail_____

Emergency Contact Person_____ (Relationship_____) Phone_____

Referring Physician_____Family Doctor_____

Okay to send note to your family doctor? YES_____NO_____ Height_____Weight_____

How did you hear about us? _____

REASON FOR
CONSULTATION:_____

How long has this been a problem?_____

Allergies_____
Latex allergy? YES_____NO_____

Do you smoke? YES____ (Per day?_____) NO____ Do you use recreational drug? YES____ NO_____

Current Medications_____

_____

Previous surgeries (year)_____

_____

Complications from surgeries_____

Past Medical History (check all that you have had)

Heart attack____ High Blood Pressure____ Diabetes_____ Bleeding Problems_____ Sleep Apnea _____
Asthma_____ Blood clots (DVT/PE)_____ Pace Maker/ Defibrillator _____ Atrial Fib_____ HIV_____
Malignant Hyperthermia___ Kidney Disease____ Artificial Heart Valve____ Hepatitis (type)_____ Cancer _____

Other_____