FRASER ORTHOPAEDIC INSTITUTE

NEW PATIENT REGISTRATION

Orthopaedic Surgery and Sports Medicine
Suite 403-233 Nelson's Crescent ■ New Westminster, BC V3L 0E3

Date: _____

Name: _____ Family Doctor: _____
Date of Birth: _____ Referring Doctor: _____
Medical Care Card: _____
Height: _____ Weight: _____
Which hand is your dominant Hand? □ Right / □ Left / □ Ambidextrous (Both)

Additional Contact Information

Cell Phone: _____ Email: _____
Home Phone: _____ Emergency Contact: _____
Address: _____
City: _____ Province: _____ Postal Code: _____

REASON FOR VISIT / TREATMENT:

□ Right Side □ Left Side □ Bilateral (Both)

□ Shoulder □ Elbow □ Wrist □ Hand/Fingers
□Hip □ Knee □ Ankle/Foot □ other: _____

When did the symptoms begin? _____
Was there an injury that triggered the symptoms? _____

Was this a workplace injury? **Yes | No**
Is there an active WorkSafeBC Claim? **Yes | No (If yes, please provide claim info below)**
Claim# _____ Date of Injury: _____
Was this from a motor vehicle accident? **Yes | No**
Is there an active ICBC claim? **Yes | No (If yes, please provide claim info below)**
ICBC Claim# _____

Have you had any treatment to date for your injury/problem? □**Yes** □ **No (if yes, please check which one)**

□ activity modification □ anti-inflammatories □ narcotics
□ physiotherapy □ occupational therapy □ chiropractic manipulation
□ massage therapy □ acupuncture therapy

Please rate your pain on the following pain scale (circle one of the numbers)

1 2 3 4 5 6 7 8 9 10
None Worse

SOCIAL HISTORY:

What is your Current Employment Status: **□ Unemployed □ Employed □ Short Term Disability □ Long Term Disability** **□ Retired □ Student (if yes, which Grade _____)** **What is your Job Title?: _____**
Tobacco (cigarettes) **□ Never □ Current Smoker: _____ (packs / day) for _____ years. □ Quit (year: _____)**
Alcohol Use **Drinks per day (circle one): □ None □ Social Only 1 2 3 4 5+**
Recreational Drug Use **□ Never □ Marijuana □ Other (list type) _____**

MEDICAL HISTORY:

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?	ADDITIONAL INFO.
Do you have any of the following heart problems? □ Coronary Artery Disease □ Heart Failure □ High Blood Pressure □ Aortic Stenosis □ Heart Valve replacement □ Angina/chest pain □ High Cholesterol □ Pacemaker □ Atrial Fibrillation □ None	
Do you have any of the following lung problems? □ Asthma □ COPD/Emphysema □ Bronchitis □ Recurrent pneumonias □ Lung Cancer □ Sleep Apnea (CPAP Machine? **Yes | No)** □ None	

Do you have any of the following gland/endocrine problems? □ Diabetes (Type 1) □ Diabetes (type2) □ Thyroid overactive (Hyperthyroid) □ Thyroid underactive (Hypothyroid) □ Osteoporosis □ Vitamin D Deficiency □ Breast Cancer □ Thyroid Cancer □ None	
Do you have any of the following Kidney or urinary tract problems? □ Kidney stones □ Kidney Cancer □ Prostate Cancer □ Kidney Failure □ Hemodialysis □ Peritoneal Dialysis □ Recurrent Urinary tract infections □ Benign Prostate Hypertrophy (BPH) □ None	
Do you have any of the following gastrointestinal? □ Heartburn/reflux/GERD □ Peptic ulcer disease □ Irritable bowel syndrome □ Liver disease/cirrhosis □ Hepatitis □ Colon Cancer □ None	
Do you have or had any of the following blood conditions? □ Pulmonary Embolism □ Anemia □ Leukemia □ Hemophilia □ HIV/AIDS □ None	
Do you have any of the following neurological conditions? □ Depression □ Schizophrenia □ Anxiety □ Seizure problems/epilepsy □ Paralysis □ Attention Deficit Hyperactivity disorder (ADHD) □ None	

Indicate any medical conditions not listed?	
Do you have any bone/joint conditions? □ Avascular Necrosis (AVN) □ Bone Tumor □ Multiple Myeloma □ Gout □ Osteogenesis Imperfecta □ Paget's Disease □ Polymyalgia Rheumatica □ Fibromyalgia □ Lupus (SLE) □ Osteoarthritis □ Rheumatoid arthritis □ None	

PAST SURGICAL HISTORY:

Type of Procedure (please list all surgeries you have had in the past)	Date

MEDICATIONS AND ALLERGIES

Current Medications	Dose		Allergies	Reaction