SEA TO SKY
ORTHOPAEDICS
Dr. Alex Brooks-Hill & Dr. Sally Clark Orthopaedic Surgeons

Welcome to Sea to Sky Orthopaedics. Please take a moment to fill in this Questionnaire.

Name: _____ **Appointment Date:** _____

Local Address: _____

Permanent Address: _____

Cell Phone: _____ **Home Phone:** _____ **Other Phone:** _____

Email address: _____

Who do you live with? *(check all that apply)*: □ alone □ roommates □ female partner □ female spouse □ parent(s) □ sibling(s) □ male partner □ male spouse □ # ___ children

Who and where is your family doctor? _____

Who referred you to Dr. Brooks-Hill/Dr. Clark? _____

Are there any other health care practitioners *(e.g., Physiotherapist)* you would like your reports to go to?

If yes, please list: _____

What orthopaedic problem are you being seen for today? **Date of injury:** _____
a) □ Right □ Left □ Bilateral (both sides) **b)** □ Knee □ Shoulder □ Elbow □ Other: _____

Date of Birth (mm/dd/yyyy): _____ **Age:** _____ **Gender:** □ Male □ Female

Height: _____ **Weight:** _____

Are you: □ Right hand dominant □ Left hand dominant □ Ambidextrous (both)?

Nationality: _____ If you are living in the Sea to Sky corridor, how long have you lived here? _____

Occupation: _____ No. of years at occupation: _____ Company Name: _____

What do you do at your job *(i.e., Computer work, heavy lifting)*? _____

Do you have a current WCB claim? □ Yes □ No **Do you have a current ICBC claim?** □ Yes □ No

If yes, Claim No.: _____ and **Date of Injury (mm/dd/yyyy):** _____

List your regular sports and recreation activities. Please indicate at what level *(i.e., Recreational, amateur competitive, professional competitive or other)* _____

_____

Provide a brief explanation of incident: _____

_____

The main problem is: □ pain □ stiffness □ instability □ weakness □ other *(describe)*: _____

Rate your problem *during the last month* from 0 - 10 *(0 = no problem, 10 = worst)*: _____

How would you describe your pain? □ no pain □ sharp □ dull □ other (describe): _____

Where is your pain? □ front □ back □ inside □ outside □ other

If you have shoulder pain, does it radiate?

□ Yes, it radiates above the elbow □ Yes, it radiates beyond the elbow □ No, it does not radiate

Do you have any numbness? □ Yes □ No If so, where? _____

What, if anything, makes your problem worse? _____

What, if anything, makes your problem better? _____

*** Not all injuries are accidents. If you are feeling unsafe, please ask the XR technician to bring a physician into the XR room for a private conversation. ***

Dr. Alex Brooks-Hill & Dr. Sally Clark Orthopaedic Surgeons
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Name: _____ **Appointment Date:** _____

Have you had any prior injury to the same body part? _____

What treatment(s) have you had for your problem? *(check all that apply)*

□ Nothing □ Physiotherapy □ Medication □ Injections □ Sling/Bracing □ Surgery □ Other

Physiotherapy – Where/Who: _____

Physiotherapy – From what date to what date? _____

What tests have you had done for your current problem?

□ X-ray □ MRI □ CT scan □ Ultrasound □ Bone Scan □ Nerve conduction studies □ Other

Please list any **medical conditions**.	**Date of first occurrence**
□ **check** here if you have no known medical conditions	
1.	
2.	
3.	
4.	

Please list all current **medications** (including homeopathic remedies)	**Amounts**
□ **check** here if you take no medications	
1.	
2.	
3.	
4.	

Please list any allergies.	**Describe Reaction**
□ **check** here if you have no known drug allergies	
1.	
2.	
3.	
4.	

Please list any **past surgeries** not listed above (type)	**Date of Surgery**	**Name of Surgeon**	**Hospital or Surgical Center**
□ **check** here if you have had no previous surgeries			
1.			
2.			
3.			

Have you/family members had any problems with general anaesthetic? □ Yes □ No
If yes, please describe: _____
Does anyone in your family have a history of a bleeding disorder? (e.g., Factor V Leiden deficiency)
□ Yes □ No If yes, please describe: _____
Do you smoke cigarettes? □ Never □ Less than 1/week □ Less than 5/day □ 5-1/2 pack/day
□ 1/2pack -1pack/day □ 1+pack/day If you were a smoker in the past when did you quit? _____
How often do you drink alcohol? □ Never □ Less than 1/wk □ 1-5/wk □ 6-12/wk □ 13-20/wk □ 20+/wk
Do you use drugs? □ Yes □ No If yes, what kind and how much? _____

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