PRAIRIE ORTHOPAEDICS & SPORTS MEDICINE

1600 Anson Road, Regina, SK S4P 0E8
www.prairieorthopaedics.com

Please review the following information to ensure it is accurate. Make any corrections as necessary.

Family Physician: _____ Referring Physician: _____

Name: _____ Health Card: _____

Gender as Stated on Health Card: ⬜ Male ⬜ Female Pronouns (Optional): _____

Date of Birth: _____ Age: ____ Email Address: _____

Address: _____ City/Prov: _____ Postal Code: _____

(Check preferred) ⬜ Home: _____ ⬜ Work: _____ ⬜ Cell: _____

Occupation: _____ **Hand Dominance:** ⬜ R ⬜ L

Emergency Contact: _____ Ph: _____ Relation: _____

WCB INFORMATION ONLY: Is this a WCB claim? □ Y □ N WCB Claim #: _____
Employer: _____

Information Regarding Current Concern: **Date of Injury:** _____ (MM/DD/YYYY)

Reason for Appointment: _____ When did this begin? _____

Has this problem: □ Improved | □ Worsened | □ Stayed the same

Similar problem before? □ Y □ N Describe: _____

Previous injuries to this area? □ Y □ N Describe: _____

Previous Specialist(s)? □ Y □ N Name: _____

□ Treatments to Date:

□ Physiotherapy | □ Chiropractor | □ Acupuncture | □ Massage | □ Cortisone Injections | □ Brace

When/where: _____ Relief? □ Y □ N

□ Home Remedies: □ Heat | □ Ice | □ Anti-Inflammatories (Advil, Naproxen, etc) Relief? □ Y □ N

□ Pain Assessment: (Select one number from 1-10 to best describe your pain within the last week)

Pain at Rest	1	2	3	4	5	6	7	8	9	10
Pain with Activity	1	2	3	4	5	6	7	8	9	10

Past Medical History: *Please check if you have or have had any of the following.*

□ **NO health issues**
□ high blood pressure
□ high cholesterol
□ diabetes
□ thyroid problems: _____
□ coronary artery disease
□ heart attack
□ heart valve issues
□ irregular heart rhythms
□ peripheral vascular disease
□ stroke
□ bleeding disorder: _____
□ anxiety
□ depression
□ asthma
□ chronic obstructive pulmonary disease (COPD)
□ respiratory issues: _____
□ sleep apnea (CPAP? □ Y □ N)
□ liver problems: _____
□ kidney problems: _____
□ history of cancer: _____
□ previous blood clot: □ Arm | □ Leg | □ Lung
□ skin issues: _____
□ other: _____

Past Surgical History: ☐ **I have NOT had any previous surgeries**

Please list any previous surgeries (including year performed). If related to your current problem, please list specific dates.

Procedure	Date of Procedure

Have YOU had a reaction to anesthetic, **other than** nausea/vomiting?	□ Y □ N	Symptoms:
Have any family members had a reaction to anesthetic, **other than** nausea/vomiting?	□ Y □ N	Symptoms:

Medications: *Please list current medications, including drug name and dosage.*

Name	Dosage	Name	Dosage

Allergies: *Please list any food or drug allergies (do **NOT** list seasonal, pets, etc).*

Allergy	Reaction	Severity *(check off)*
		□ mild □ mod □ severe
		□ mild □ mod □ severe

Do you smoke? □ Y □ N How much? _____
Do you vape? □ Y □ N How much? _____
Do you use marijuana? □ Y □ N How much? _____
Do you consume alcohol? □ Y □ N How much? _____