WHITE ROCK
ORTHOPAEDIC
SURGERY CENTRE

Ste 44 - 1480 Foster Street White Rock, BC V4B 3X7
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ARNO SMIT, M.D., F.R.C.S.(C) ORTHOPAEDIC SURGEON

V 1.3 November 29, 2007

Patient registration (to be completed by patient)

Last Name: ______________________________Given name(s):____________________________________

Date of birth: _____________________________ Care Card #:_____________________________________

Address: ____

City/town: ______________________________ Province: _______ Postal Code: ___________________

Tel: (Home):_________________________ (Work): ____________________ (cell): ___________________

(Other): _________________ Fax: ______________________ E-Mail: ______________________________

Referring physician: ___________________________ Family physician: ______________________________

New Patient: Yes_______ No ______

WCB: Yes __________ No __________WCB# _________________________DOI:_____________________

Body weight: (Kg / Lbs): _________________ Height: (Meter / Feet): ________________________

Smoker? Yes ____ No ____ How much and for how long? _________________________________

Ever smoked? Yes ___No ____ How much, for how long, cessation date? _________________________

Alcohol consumption? Yes____ No ____ how much, how often? _________________________________

Occupation or main daily activity: ____

Is the patient currently working or performing his/ her main daily activity? Yes___ No _____

Recreational physical activity: ____

Is the patient right handed or left handed? Right ____________ Left _______________

Does the patient have help or support at home? Yes _____ No _____

Explain: ____

Does the patient have dependents at home? Yes ____ No ____ Explain:__________________

Does the patient need to use stairs in or around the ho Yes ___No ___ Explain:__________________

Is the patient responsible for his/her own affairs? Yes ____No ___ Explain: ___________________________

Current medication, incl. herbal and alternative remedies (a list can be photocopied by the receptionist):
____
____
____
____
____
____

Allergies: ____
____

Has the patient ever had surgery or an anaesthetic? Yes ___ No ___ Please provide appropriate detail re nature of procedure, location of surgery and surgeon, complications of surgery or anesthetic, if applicable, (approximate) date.

____
____
____
____
____

Has the patient ever experienced any significant medical illness(es)? Yes ____ No _____ Please provide appropriate detail re nature of illness, treating physician, complications if applicable, (approximate) date.

____
____
____
____

Does the patient have:

-diabetes Yes _______ No ________
- high blood pressure? Yes ________ No ________
- heart disease or condition? Yes ________ No ________
- lung disease or condition? Yes ________ No ________
- liver disease or condition? Yes ________ No ________
- gallbladder disease or condition? Yes ______ No ______
- pancreas disease or condition? Yes ______ No _______
- stomach/bowel disease or condition? Yes _____ No _____
- disease or condition of urinary tract ? Yes ______No _____
- disease or condition of reproductive organs (for men: incl prostate)? Yes ____No_____
- disease or condition of breast(s)? Yes ______ No ______
- disease or condition of endocrine glands, incl thyroid? Yes _______ No ________
- mental illness or condition? Yes_______ No_____
- permanent disability or impairment? Yes_______ No_____
- rheumatological illness or condition, incl fibromyalgia, osteoarthritis? Yes___ No_____
- any implanted device? Yes_______ No_____ Explain:
- any metallic foreign body, including surgical clips, metal in the eye, shrapnel Yes__No_

Explain:

Reason for referral or current complaint:

Body area or part: ____________________ **Right or Left?** **R / L (circle one)**

Pain: Yes_______ No_____. Explain
Locking, catching, giving way: Yes_______ No_____Explain
Falls/ near falls: Yes_______ No_____Explain
Loss of function: Yes_______ No_____ Explain
Deformity: Yes_______ No_____Explain
Sleep disturbance: Yes_______ No_____Explain
Related to injury? Yes_______ No_____
Sudden or gradual onset?
Continuously present OR problematic from time to time? (CIRCLE ONE) Explain:

Please provide detail re. circumstances leading to injury or current complaint, nature of injury or current complaint, date of injury or onset of current complaint.

____
____
____

Treatment received so far (medication/ physio/ orthotics/ surgery/ other specialist assessments/ etc.).Please provide detail: ____
____

Investigations so far:
X-rays Yes_______ No_____ date and location:
CT Yes_______ No_____ date and location:
MRI Yes_______ No_____ date and location:
Bonesecan Yes_______ No_____ date and location
Ultrasound Yes_______ No_____ date and location
Laboratory investigation Yes_______ No_____ date and location

Did the patient read and sign the **Facility Mission and Procedures** document? Yes_______ No_____
If not, explain:
Does the patient wish to receive a copy of medical information added to the medical file with each appointment, as outlined in the **Facility Mission and Procedures** document? An administrative fee applies to this service.

Patient registration completed by:

	Print name	**Signature**	**Date**
Patient (fully/partly)			
Physician (fully/partly)			
Other (fully/partly)			

NOTE: – for conditions related to the lower extremities (leg/foot)→ please bring **shorts.**
– for conditions related to the upper extremities (shoulder/ hand) → please bring **sleeveless shirt or tank top**.