**Dr. Alex Brooks-Hill**
BPHE MD FRCSC(ortho)DipSportMed
Orthopaedic Surgeon

**Dr. Sally Clark**
MD MHA FRCSC (ortho)
Orthopaedic Surgeon

Sea to Sky Orthopaedics Athletic Injuries and Arthroscopy
PO Box 1275, Whistler BC, V0N 1B0 | T 604 905 4075 F 604 905 4073 | www.seatoskyorthopaedics.com

**Welcome to Sea to Sky Orthopaedics! Our team would like to know a few things about you prior to your appointment. Please take a moment to fill in this Questionnaire.**

Date of appointment: Name:

Local Address: Permanent 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

Home Phone: Cell Phone: Other Phone:

Email address:

Who referred you to Dr. Brooks-Hill/Dr. Clark/Dr. Douglas? Who and where is your family doctor?

What orthopaedic problem are you being seen for today?

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 (ie. 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 (ie. Recreational, amateur competitive, professional competitive or other)

**Date of appointment:**_____ **Name:** _____

**HISTORY OF INJURY**

Did your problem come on gradually or as a result of an injury? □ Gradually

□ Injury

Date of onset/injury:
___/___/___
mm/dd/yyyy

Provide a brief explantion of incident:

The main problem is: □ Pain (decribe): ◯ Constant ◯ Intermittent

□ Stiffness □ Instability □ Weakness □ Other (describe)

Rate your problem during the last month (circle): No problem 0 1 2 3 4 5 6 7 8 9 10 Worst

How would you describe your pain? □ No pain □ Sharp □ Dull

□ Other (describe)

Where is your pain? □ front □ back □ top □ inside □ ouside

□ other (describe)

If you have shoulder pain, does it radiate? □ Yes, it radiates to above the elbow □ Yes, it radiates to beyond the elbow

□ No, it does not radiate

What, if anything, makes your problem worse?

What, if anything, makes your problem better?

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

| Treatment | Where/Who | From what date to what date? |
|---|---|---|
| □ Nothing | | |
| □ Physiotherapy | | |
| □ Medication | | |
| □ Injections | | |
| □ Sling/Bracing | | |
| □ Surgery | | |
| □ Other | | |

What tests have you had done for your problem? □ X-ray □ MRI □ CT scan

□ Ultrasound □ Bone Scan □ Nerve conduction studies

□ Other_____

**Date of appointment:**_____ **Name:** _____

**Other Medical History**

| Please list any **medical conditions**. | Date of first occurrence |
|---|---|
| □ check here if you have no known medical conditions | |
| | |
| | |
| | |
| | |

| Please list all current medications (inlcuding homeopathic remedies) | Amounts |
|---|---|
| □ check here if you take no medications | |
| | |
| | |
| | |
| | |

| Please list any **allergies**. | Describe the reaction |
|---|---|
| □ **check** here if you have no known drug allergies | |
| | |
| | |
| | |
| | |

| Please list any **past surgeries** not listed above (type) | Date of Surgery | Name of Surgeon | Name of Hospital/Surgical Centre |
|---|---|---|---|
| □ check here if you have had no previous surgeries | | | |
| | | | |
| | | | |
| | | | |

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? (eg. 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? ___/___/___
mm/dd/yyyy

How often do you drink alcohol? □ Never □ Less than 1/week □ 1-5/wk

□ 6-12/wk □ 13-20/wk □ 20+/wk



Do you use drugs? Yes No If yes, what kind and how much?