ALEXANDER RABINOVICH
ORTHOPAEDIC SURGEON
BSc MD FRCSC

PATIENT – INFORMATION

DATE: _____

FULL NAME:	**DATE OF BIRTH:**	**FAMILY DOCTOR:**
GENDER:	**HEALTH CARD:**	**REFERRING DOCTOR:**
ADDRESS:	**HOME PHONE:**	**OCCUPATION:**
	WORK PHONE:	**WSIB YES / NO – CLAIM #:**
CITY:	**CELL PHONE:**	**MVA YES / NO – CLAIM #:**
POSTAL CODE:	**EMAIL:**	**INSURANCE COMPANY:**

WHERE DOES IT HURT YOU?

☐ **LEFT** ☐ **RIGHT**

☐ TOE (S)	☐ HIP	☐ SHOULDER
☐ FEET	☐ THIGH	☐ ARM
☐ HEEL	☐ PELVIS	☐ ELBOW
☐ ANKLE	☐ BACK	☐ FOREARM
☐ LEG	☐ NECK	☐ WRIST
☐ KNEE	☐ CHEST	☐ HAND

HEIGHT: _____ **WEIGHT:** _____

SHOE SIZE: _____

DO YOU SMOKE: YES / NO – HOW MANY: _____

DRINK ALCOHOL: YES / NO – HOW MANY: _____

DATE OF INJURY/ONSET OF SYMPTOMS: _____

HOW DID INJURY/SYMPTOMS BEGIN: _____

_____

_____

_____

WHAT MAKES IT WORSE: _____

WHAT MAKES IT BETTER: _____

RATE YOUR PAIN: **(LEAST) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (WORST)**

WHAT TREATMENTS HAVE YOU HAD: _____

☐ **PHYSIOTHERAPY** ☐ **MASSAGE** ☐ **ORTHOTICS**
☐ **CHIROPRACTIC** ☐ **ACCUPUNCTURE** ☐ **BRACING**
☐ **INJECTIONS:** _____

DO YOU HAVE LATEX ALLERGY - YES / NO

LIST YOUR DRUG ALLERGIES

LIST YOUR MEDICATIONS or ATTACH LIST

SELECT ANY MEDICAL CONDITIONS YOU HAVE

☐ DIABETES (TYPE 1 OR 2)
☐ ARTHRITIS TYPE: _____
☐ OSTEOPOROSIS / BONE DISEASE: _____
☐ BLOOD PRESSURE (HIGH OR LOW)
☐ HIGH CHOLESTEROL
☐ HEART ATTACK (DATE): _____
☐ ARRHYTHMIA: _____
☐ SLEEP APNEA, ASTHMA, COPD EMPHYSEMA
☐ BLEEDING DISORDER: _____
☐ HIV, HEP B/C or INFECTION: _____
☐ PSYCHIATRIC: _____
☐ BLOOD CLOTS / EMBOLISM: _____
☐ STROKE / TIA (DATE): _____
☐ IMMUNOLOGIC / HEMATOLOGIC: _____
☐ LIVER / PANCREATIC DISEASE: _____
☐ KIDNEY / BLADDER DISEASE: _____
☐ BOWEL / STOMACH DISEASE: _____
☐ SEIZURES / NEUROLOGICAL: _____
☐ CANCER: _____
☐ **MALIGNANT HYPERTHERMIA: YES / NO**

PREVIOUS SURGERY
(DATE, TYPE, SURGEON)

_____

_____

_____

_____

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