

Dr. Brian P. Fraser, MD, FRCS(C)
Orthopaedic Surgeon

Patient Name: _____ Appointment Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____ Occupation: _____

Current complaint(s): _____

Referring Physician: _____ Family Physician: _____

Do you have a current WSIB claim? If yes, claim number: _____ Date of injury: _____

Do you have problems with Anesthesia? ☐ YES ☐ NO If yes, explain: _____

Allergies to medications / Difficulties with medication:

_____

Medications: (please include prescription and non-prescription)

Medication	Dose	# times/day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History: Check if you have or had any of the following medical problems. Please indicate if the problem is current (even if it is being treated), or resolved.

☐ None
☐ Anxiety/Depression
☐ Arthritis (where?) _____
☐ Asthma
☐ Bleeding problems
☐ Blood clot (where?) _____
☐ Cancer (type?) _____
☐ COPD/Emphysema/Lung disease
☐ Coronary Artery Disease
☐ Diabetes Type I / II
☐ History of heart attack
☐ Hepatitis A / B / C
☐ HIV / AIDS
☐ Heart murmur/ valve problem
☐ High cholesterol
☐ High Blood Pressure
☐ Rheumatoid Arthritis
☐ Gastro-intestinal problems
☐ Kidney disease
☐ Other: _____
☐ Liver disease
☐ GERD (reflux)
☐ Peripheral vascular disease
☐ Psychiatric disorder: _____
☐ Sleep Apnea
☐ Stroke
☐ Thyroid disease
☐ Osteopenia / Osteoporosis
☐ Immune disorder (Lupus, etc)

Surgical History: Please list any previous surgeries.

☐ None

Surgery and Surgeon	Date(s)
_____	_____
_____	_____
_____	_____
_____	_____

Were there any complications?

☐ None

_____

_____

_____

_____

_____

Family History: Please list any diseases affecting your family members.

Father: _____ If deceased, cause of death and age at death_____

Mother: _____ If deceased, cause of death and age at death_____

Siblings: _____ If deceased, cause of death and age at death_____

Social History:

Do you smoke tobacco products? ☐ YES, _____ cigarettes(s) per day ☐ NO
IF, NO ☐ never smoked ☐ former smoker

Do you drink alcohol? ☐ YES ☐ NO Number of drinks per day? _____ per week? _____

Do you take street drugs? ☐ YES ☐ NO Please specify: _____

Everything that I have answered is true and correct to the best of my knowledge.

_____ Date: _____/_____/_____
Patient Signature

PLEASE NOTE THERE IS A $100 LATE CANCELLATION FEE, 48 HOUR NOTICE IS REQUIRED TO AVOID THIS FEE