HAND CLINIC PATIENT WORKSHEET

Please complete once only, on your first visit. Do not repeat at follow-up appointments. Please ask if you need help.

Name:_____ Date:_____
Alberta healthcare number:_____
Other provincial health care number:_____ Province: _____

Right handed ☐ Left handed ☐ Height:_____ Weight:_____

Is this a WCB injury? No ☐ Yes ☐ Claim number: _____

WHY ARE YOU COMING TO SEE DR ELZINGA, LIST YOUR MEDICAL CONDITION AND SYMPTOMS:

_____
_____
_____

WHEN DID YOUR SYMPTOMS START (date):_____

PLEASE LIST YOUR MEDICAL PROBLEMS, include physical and mental health:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please check all medical conditions that apply (medical problems that you have or have had in the past):

☐ Heart attack	☐ Cancer	☐ Blood clot (legs, lungs, etc)
☐ Heart failure	☐ Fibromyalgia	☐ Bleeding disorder (easy bleeding, etc)
☐ Abnormal heart rhythm	☐ Diabetes	☐ Osteoporosis
☐ Artificial heart valve	☐ Artificial joint	☐ Obstructive sleep apnea
☐ Pacemaker	☐ Hepatitis, type: _____	☐ COPD
☐ Stroke	☐ HIV, AIDS	☐ Kidney disease
☐ Rheumatoid arthritis	☐ Tuberculosis	☐ Liver disease

Details:

_____
_____

PLEASE LIST YOUR MEDICATIONS, include hormones, non-prescription medications, vitamins, supplements, etc**:**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please check off any of the following medications that you take:

Diabetes medications: ☐ Metformin ☐ Insulin ☐ Other: _____
Blood thinner: ☐ Baby aspirin (80-81 mg daily) ☐ Full dose aspirin (325 mg daily) ☐ Other:_____

PLEASE LIST YOUR ALLERGIES:

Medication, environmental, tape, etc	Reaction	Year reaction occurred

Are you allergic to latex: Yes ☐ No ☐

PLEASE LIST ANY PREVIOUS SURGERY:

Type of Surgery	Year Surgery Performed

Have you ever had a problem with general anesthesia: Yes ☐ No ☐
Details:_____
_____

SOCIAL HISTORY:

Occupation: _____
Do you smoke? Never ☐ Quit ☐ Year: _____ Yes ☐ How much per week? _____ packs
How many alcoholic drinks do you drink per day? _____
Do you use marijuana? No ☐ Yes, medicinal ☐ Yes, recreational ☐
Do you use any other recreational drugs? No ☐ Yes ☐ Please list: _____

FAMILY HISTORY - Have any of your blood relatives had the following medical conditions:

Medical Condition	Family Member	Details
Cancer		
Heart disease		
Stroke		
Easy bleeding or clotting disorder		
Problems with general anesthesia		
Musculoskeletal or rheumatologic disease		

PLEASE LIST ANYTHING ELSE YOU WOULD LIKE US TO KNOW:_____
_____

NO SHOW FEES

We require at least 24 hours notice for any appoitnemtn cancellations. If you do not show up for an appointment or cancel with less than 24 hours notice, a no-show fee will apply.

CONSENT FOR METHODS OF COMMUNICATION - I consent to Dr. Elzinga and/or her office staff contacting me by:

- ☐ Telephone: _____
- ☐ Email: _____
- ☐ Fax: _____
- ☐ Emergency contact name and phone number: _____

I acknowledge that information sent via the above means may not be confidential and/or secure:
Patient signature: _____ Date: _____