

NEW 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 YOU SYMPTOMS STARTS (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):

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood clot (legs, lungs, etc) |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Bleeding disorder (easy bleeding, etc) |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Obstructive sleep apnea |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hepatitis, type: _____ | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV, AIDS | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> 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 appointment 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: _____

Dr. Kate Elzinga, MD FRCSC – Plastic and reconstructive surgery