**COLIN M. JACKSON, MD, Inc.**

**General Orthopaedic & Trauma Surgeon – Hand, Wrist & Elbow Subspecialty**

Name:       Family Doctor:

Occupation:       Referring Doctor:

Age:     Sex:**[ ]** Male [ ]  Female Height:ft.    in. Weight:lbs.

Address:

Home Phone:       Cell:       Bus. Number:

Hand Dominance: [ ]  Right [ ]  Left [ ]  Both

WCB or ICBC RELATED:**[ ]** YES [ ]  NO If YES, please provide: Claim #

Date of Injury(DD/MM/YYYY)**:** **/****/**

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**MEDICAL HISTORY:**

Diabetes [ ]  Prolonged Bleeding [ ]

High Blood Pressure [ ]  Anemia [ ]

Heart Trouble (heart [ ]  Blood Clots (Legs, Lungs) [ ]

attack, angina, irregular rhythm) Hiatus Hernia/Heartburn [ ]

Stroke [ ]  Depression or Anxiety [ ]

Seizures [ ]  Other Medical Problems [ ]

Lungs/Breathing [ ]

**Sleep apnea** [ ]  Please provide details for ‘YES’ answers:

Liver (Hepatitis,Cirrhosis) [ ]

HIV/AIDS [ ]

Thyroid Problems [ ]

**Surgical History:**

Have you had any previous operations? [ ]  YES [ ]  NO

Difficulties with anesthesia? [ ]  YES [ ]  NO

Family history of anesthesia problems? [ ]  YES [ ]  NO

Please provide details and dates for ‘YES’ answers:

**Please list your Medications and Doses:**

**Do you have any Drug Allergies?** Please list drug(s) and describe reaction

Do you smoke? [ ]  YES [ ]  NO Quantity:

Drink alcohol? [ ]  YES [ ]  NO Quantity :

Non-prescription drug use? [ ]  YES [ ]  NO Quantity:

What is the **current** problem?

Was this the result of an injury?

What are your current limitations?

What treatments have you had to date? (*Medication, Physical therapy, splints/braces, surgery*)

**Sports & Recreation:** Please list your athletic activities of interest: