**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: