Patient Information

Dr. Jacqueline Smith Auguste
orthopaedic surgeon

Name_____
Referring Physician_____
Family Physician _____
Address_____
City_____Prov_____Postal Code_____
Home Phone_____Cell Phone_____
Age_____ Birthdate_____ Sex: Male / Female
Emergency contact name _____ Phone__ _____
Your e-mail address _____ _____
OHIP number _____ WSIB number (if applicable)_____
Occupation_____

Medical History

Please check if you have had any of the following:

- ❑ Childhood diseases
- ❑ Cancer
- ❑ Stomach ulcer
- ❑ Seizures
- ❑ Irregular heartbeat
- ❑ HIV / AIDS
- ❑ Colitis
- ❑ Blood transfusions
- ❑ High blood pressure
- ❑ Tuberculosis
- ❑ Psychiatric problems
- ❑ Thyroid disease
- ❑ Bleeding problems
- ❑ Heart problems
- ❑ Hepatitis
- ❑ Kidney stones
- ❑ Blood clots
- ❑ Sexually transmitted diseases
- ❑ Rheumatoid arthritis
- ❑ Fibromyalgia
- ❑ Asthma
- ❑ Diabetes
- ❑ Alcohol abuse
- ❑ Stroke
- ❑ Drug abuse
- ❑ High cholesterol
- ❑ Emphysema
- ❑ Endometriosis
- ❑ Broken bones
- ❑ Breast lumps
- ❑ Urinary infections
- ❑ Scoliosis
- ❑ Pneumonia
- ❑ Osteoporosis
- ❑ Leg length inequality
- ❑ Liver disease
- ❑ Gout
- ❑ Ankylosing Spondylitis
- ❑ Lupus
- ❑ Rheumatic fever

If other conditions, please list:

_____
_____
_____
_____

Are you pregnant? (circle) Yes / No

Medication Record

□ Always bring an updated medication list to all future appointments.

Please list current: prescriptions, over-the-counter medications, and alternative remedies Indicate if you cannot remember all of your medications:

Surgical History

Please list all surgeries with approximate year according to the categories listed:

Skin / Plastic:
_____

Eye:
_____

Brain:
_____

Ear/Nose/Throat:
_____

Cardiovascular:
_____

Pulmonary:
_____

Abdominal:
_____

Female:
_____

Male:
_____

Spine:
_____

Joints:
_____

Bones:
_____

Other:
_____

Social History

Please circle or fill in the blank:
Have you ever required a blood transfusion? Yes / No Date_____
Have you ever smoked? Yes / No _____ packs a day for _____ years total If quit, when _____
Do you drink alcohol? Yes / No How many drinks per week?_____
Do you take any recreational drugs? Yes / No Which drugs? _____

Please Sign and Date:

Signature_____Date_____