Dr. Tanner Dunlop MD, FRCSC*

Orthopedic Surgeon

Upper Extremity & Sports Medicine

** Dr. Tanner Dunlop Surgical Professional Corporation*

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New Patient Information Form: Please fill out this form prior to being seen by Dr. Dunlop and bring it with you to your appointment.
This form is intended to improve our efficiency, allowing us to spend more time focusing on your concerns. Thank you!

Demographic Information:

Name: _____ Health Card Number: _____
Date of birth: _____/_____/_____ (mm/dd/yyyy) Age: _____ Gender: Male / Female
Family Physician: _____ Referring Physician: _____
Address: _____ City/Province: _____ Postal Code: _____
Home: _____ Work: _____ Cell: _____
Preferred phone #: Home / Work / Cell May we leave messages on preferred phone? Y / N
Email address: _____ May we contact you electronically via email? Y / N
Occupation: _____ Hand dominance: Right / Left / Ambidextrous
Hobbies: _____
Marital status: single / married / common-law / other _____
Spouse's name: _____ Spouse's contact phone #: _____
Emergency contact name: _____ Relationship: _____
Emergency contact phone #: _____

WCB INFORMATION ***ONLY*:**
Is this a Worker's Compensation Board claim? Y / N If so, WCB Claim #: _____
Date of Injury: _____/_____/_____ (mm/dd/yyyy) Employer's Name: _____

Information Regarding Current Concern

Reason for Appointment:_____

_____

When did this begin? _____
Has this problem: □ improved □ worsened □ stayed the same
Have you had this or a similar problem before? Y/N If so, describe:_____
Have you had previous injuries to this area? Y/N If so, describe:_____ _____
Previous treatment for this problem? Y/N *If so, which types and did you experience any relief*?
□ physician, name: _____ Relief? Yes/ No
□ physical therapy, who/where? _____ Relief ? Yes/ No
□ chiropractic, who/where? _____ Relief ? Yes/ No
□ acupuncture, who/where? _____ Relief ? Yes/ No
□ massage, who/where? _____ Relief ? Yes/ No
□ exercise therapy, who/where? _____ Relief ? Yes/ No
□ medications, list: _____ Relief ? Yes/ No
□ heat □ ice
□ other: _____
_____

Pain Assessment (*circle one number from 1-10 to best describe your pain within the last week*)

Pain At Rest	1	2	3	4	5	6	7	8	9	10
Pain with Activity	1	2	3	4	5	6	7	8	9	10

Medical History

Past Medical History: *Please check all that apply:*

□ **NO health issues current or past**

□ high blood pressure
□ high cholesterol
□ diabetes
□ hearing problems
□ vision problems
□ coronary artery disease
□ heart attack
□ heart valve issues
□ irregular heart rhythms
□ peripheral vascular disease
□ stroke
□ asthma
□ chronic obstructive pulmonary disease (COPD)

□ other respiratory issues _____
□ bleeding disorder _____
□ kidney problems _____
□ liver problems _____
□ history of cancer _____
□ previous blood clot _____
□ recent hospitatlization _____
□ other: _____
_____
_____

Past Surgical History: *Please list any and all previous surgeries and year performed. If related to your current problem, please list specific dates and surgeons if able.*

□ **I have NOT had any previous surgeries**

_____
_____
_____
_____

Have you ever had a reaction to anesthetic? **Yes / No** Symptoms: _____
Have any family members ever had a reaction to anesthetic? **Yes / No** Symptoms: _____

Medications: *Please list **ALL** current medications and supplements, including drug name and dosage. If you require more space, please attach a separate page.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: *Please list any food or drug allergies you have (you do not need to list seasonal, pets, etc.)* ***Please also indicate reaction (eg: rash, swelling, anaphylaxis, etc) and severity of each allergy.***

_____
_____
_____
_____

Do you smoke? Yes / No If yes, how much? _____

Do you consume alcohol? Yes / No If yes, how much? _____

Do you exercise regularly? Yes / No If yes, what do you do and how often? _____
_____
_____

Please complete this form and bring it with you to your appointment. Thank you!