

PATIENT'S NAME _____ DATE _____

GREG ERENS, M.D.

COULD YOU PLEASE PROVIDE DR. ERENS WITH THE NAME OF YOUR PRIMARY CARE PHYSICIAN AND THE NAME OF THE PHYSICIAN WHO REFERRED YOU TO DR. ERENS.

PRIMARY CARE PHYSICIAN

NAME _____
ADDRESS _____
CITY/STATE _____
PHONE NUMBER _____

REFERRING ORTHOPAEDIST

NAME _____
ADDRESS _____
CITY/STATE _____
PHONE NUMBER _____

OTHER

NAME _____
ADDRESS _____
CITY/STATE _____
PHONE NUMBER _____

NEW PATIENT FORM - DR. ERENS

Patient Name: _____

Date: _____

Age: _____ Male Female

Reason for Visit: _____

Who Referred You?: _____ MD Friend Patient

Physicians who follow you regularly (PCP, cardiologist, etc.):

Medical Problems:

Previous Surgeries: (list dates)

Appendectomy _____

Tonsillectomy _____

Hernia Repair _____

Gallbladder _____

Hysterectomy _____

Knee Arthroscopy _____

Total Knee Replacement _____

Total Hip Replacement _____

Have you ever had a surgical infection? YES NO (If yes, where? _____)

Have you ever had general anesthesia? YES NO

Any Problems with Anesthesia? YES NO (Problem: _____)

Allergies to Medications:

Current Medications: (with doses)

Social History:

Occupation: _____

Working: Full Time Part Time Student

If not working, are you: Retired On Disability Unemployed

Marital Status: Single Married Divorced Separated Widowed

Number of children: _____

Who lives with you?: _____

Do you smoke tobacco? YES NO I QUIT

Number of packs per day: _____

Do you drink alcohol? YES NO I QUIT

Number of drinks per week: _____

Do you use street drugs? YES NO I QUIT

Which drugs: _____

Are you pregnant? YES NO

Family History: (list which family member)

High Blood Pressure

Cancer: Breast Lung Prostate Thyroid Skin Other: _____

Heart Disease

Diabetes

Thyroid Disease

Anesthesia Complications

Other: _____

Have you ever had or experienced:

- | | | |
|---|---|--|
| <input type="checkbox"/> Vision/Eye Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fevers/Chills | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of Feet/Ankles | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Blood Clots in Legs | <input type="checkbox"/> Vomiting of Blood | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Kidney Failure/Dialysis | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Lumbar Spine |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Recurrent Bladder Infections | <input type="checkbox"/> Cervical Spine |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Hypothyroidism |
| | | <input type="checkbox"/> Hyperthyroidism |

		No Pain					Severe Pain					
		☺					☹					
What Hurts?	<input type="checkbox"/> Right Hip	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> Left Hip	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> Right Knee	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> Left Knee	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> Spine	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/> _____	0	1	2	3	4	5	6	7	8	9	10

How long have you had this pain? (Months, Years) _____

Was this the result of an injury? YES NO

If Yes, Date of Injury: _____

Lawsuit Pending: YES NO

Workers' Compensation: YES NO

What makes the pain better? _____

What makes the pain worse? _____

Do you use any of the following:

Cane Crutches Walker Wheelchair

How do you walk stairs?

One leg after the other (normal)

Lead with same leg each time

Do you need a rail to walk up/down stairs? YES NO

How far can you walk before limited by pain: _____

What have you tried to help the pain?

- Ice
- Rest/Decreased activity
- Physical Therapy
- Pain Medication: Percocet Vicodin Lortab Oxycodone OxyContin
- Anti-inflammatory: Vioxx Celebrex Bextra Aspirin
- Ibuprofen Motrin Advil Alleve Naprosyn

Glucosamine/Chondroitin Sulfate

Injections

Hip Knee Spine

When was your last injection? _____

How long did your injection last? __ Days __ Weeks __ Months __ Years

How many total injections have you had? _____

Orthotics

Acupuncture

Chiropractor

Cane

Brace

Other _____