New patients and patients arriving for new problems need to arrive 15 minutes before their scheduled appointment time. If you are not early the appointment will be rescheduled.

Dr.Enns New Patient Questionnaire

Form A

NAME:________________________________DOB:____________AGE:_____S:____MRN:____________DOV:___________

Please answer the questions below to help us know more about you and the reason for your visit today.

1. What problem are you here to have addressed today?

____

____

____

2. How long has this been a problem? (Circle one)

Days weeks months years

3. Did you have an injury? (Circle one) yes no

If yes, what was the date of injury: _______

Briefly describe the injury:

____

____

____

4. Have you ever had surgery on the affected joint(s)?

(circle one) yes no

If yes, when was surgery done and who performed it?

____

____

____

Briefly describe the surgery:

____

____

____

***If the affected joint(s) have been replaced, please also fill out FORM B**

5. How often do you experience symptoms?

(circle one) 1 – 2 – 3 – 4 – 5 – 6 – 7 days per week

6. On average, how severe is the pain?

1= minimal soreness, 10= worst pain imaginable

(circle one) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

7. Do you have any? (circle any that apply)

Numbness Tingling Weakness

8. Do you have any? (circle all that apply)

-Mechanical Symptoms: snapping/clicking/popping/grinding

-Instability

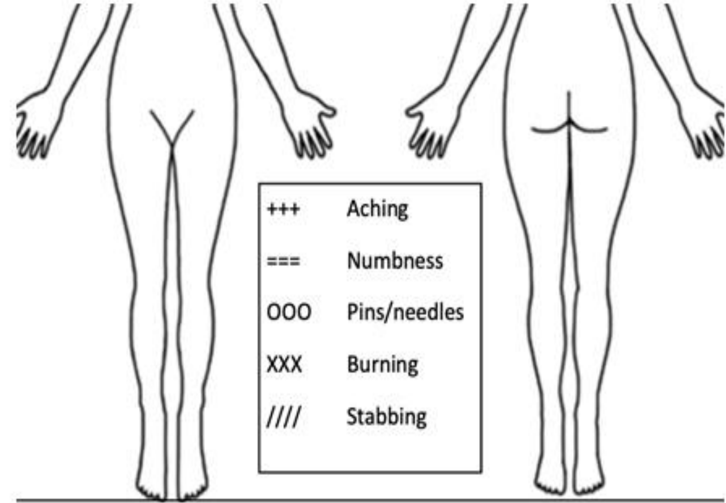
-Effusion/swelling

9. Do you require walking assistive devices? (circle one)

No Cane Walker Wheelchair

10. Where are you experiencing pain?

(Indicate with appropriate symbols on the drawing below)



11. What activities make your symptoms WORSE? (circle all that apply)

sitting standing walking exercise

driving stairs lifting lying down

bending forward bending backward

Other:_________________________

12. What activities make your symptoms IMPROVE?(circle all that apply)

sitting standing walking exercise

driving stairs lifting lying down

bending forward bending backward

Other:_________________________

13. What activities are difficult because of this problem? (e.g. daily activities of living, work, leisure etc.)

____

____

____

____

____

(Updated 05/15/2022)

(Scan: MD Specific)

14. What treatment(s) have you tried? (circle all that apply)
Physical Therapy Exercise Weight Loss

Bracing Ice/Heat Activity Modification

Pain Medication Anti-Inflammatory Medication

Other: ____

15. Have you tried injection(s)?
(circle one) yes no
If yes, when was the last injection done?
____

16. Have you had any recent diagnostic imaging? (circle all that apply)
X-Ray MRI CT Scan
Nerve Study Bone Scan Other: ____________

17. What do you do for a living?__________________

18. Marital status? (circle one) Married Single

19. Where do you live? (circle one)
House Apartment Facility
Other: _____________________

20. Do you use nicotine products? Yes No
If yes, how much in packs/products per day? _____
Do you plan to quit?_________

21. Do you regularly consume alcohol? Yes No
If yes, specify how many drinks per week: ______

22. Do you use illicit drugs? Yes No
If yes, please specify: ________________________________

23. Have you ever had MRSA (Methicillin –resistant Staph Aureus) infection or colonization? (circle one) Yes No

24. Have you ever had an infection of a surgical site? (circle one) Yes No

25. Do you have history of heart problems? Yes No
If yes, briefly specify: ______________________________
____
Who is your Cardiologist? __________________________

26. Do you have Diabetes Mellitus? (circle one) Yes No
If yes, how do you manage your blood sugar? (circle all that apply)
Diet Oral Medication(s) Insulin

What is your last known A1C value?_________________

27. Do you take any significant blood thinners? (circle one)
Yes No
If yes, which medication(s): __________________________

28. Do you have a personal or family history of deep vein thrombosis or blood clotting disorders? (circle one)
Yes No
If yes, briefly describe:___________________________

29. Do you take any immunosuppressive medication(s)?
(circle one) Yes No
If yes, please list: _________________________________
____

FOR OFFICE USE:

Vitals: Ht_________ Wt_________ BMI _________

Exam:

PMH:
____
____
____

PSH:
____
____
____

Allergies:
____
____

Meds:
____
____

Notes:
____
____
____
____
____
____

Plan:

Obs **Inj** **PT** **Weight Loss** **Brace**

Labs __________________ **Imaging** __________________

Surgery
____
____
____

Dr. Enns NP Questionnaire Form B

(ONLY COMPLETE THIS FORM IF YOU PREVIOUSLY HAD A JOINT REPLACEMENT & ARE SEEING DR. ENNS FOR THAT SAME JOINT/BODY PART)

Name:____Date:______________MRN:______________

Please answer the questions below to help us know more about you and the reason for your visit today.

1. When was the affected joint replaced and by whom?

____
____
____

2. Did you experience any post-operative complications?
(e.g. medical, wound, uncontrolled pain, infection, stiffness, dislocation, fracture, DVT) Yes No
If yes, please specify: _________________________

____
____
____
____
____
____

3. When was your last follow-up visit for the replaced joint with the surgeon who replaced it?

____

4. Has the replaced joint undergone any further surgery?
(circle one) Yes No
If yes, specify date, surgeon and the surgery:

____
____
____
____
____
____

5. Did the replaced joint undergo any surgeries prior to replacement?
(circle one) Yes No
If yes, specify date(s), surgeon and the surgery:

____
____
____
____
____
____

6. Have your pre-operative symptoms resolved after replacement?
(circle one) Yes No
If no, specify: _________________________________

____
____
____
____
____
____

7. Are you currently satisfied with the replaced joint?
(circle one) Yes No
If no, specify: _________________________________

____
____
____
____
____
____

8. Do you trust your replaced joint?
(circle one) Yes No
If no, specify: _________________________________

____
____
____
____
____
____

9. Have you recently experienced any of the following?
(circle all that apply)

Warmth around the joint
Redness
Effusion (swelling fluid in/around joint)
New onset of significant pain without trauma
Drainage
Incision breakdown
Constitutional symptoms of illness
(fever, malaise, chills, body aches)