



# Erik N. Zeegen, M.D.

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Ref MD: \_\_\_\_\_

Age: \_\_\_\_\_

Address: \_\_\_\_\_

Where is your pain:       Lower Back       Hip       Knee

Which side?       Right       Left       Both

Please describe your problem:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTES FOR DR. ZEEGEN:**

How long has it been hurting? \_\_\_\_\_ Pain has worsened in last \_\_\_\_\_ (months/year)

Hx of Injury:    No       Yes When/How? \_\_\_\_\_

Medications tried? \_\_\_\_\_ Benefit? \_\_\_\_\_  P.T./ last? \_\_\_\_\_

Hx of **Oral Prednisone**? When? \_\_\_\_\_ Dosage? \_\_\_\_\_ How Long? \_\_\_\_\_

Walker/Cane.....Which hand?    Right       Left

Walking distance? \_\_\_\_\_  Pain up and down

**Knee Symptoms:**

Swelling       Redness/Erythema

Giving Way/Buckling       Catching/Popping

Pain up/down stairs       Pain s/p long sitting

Bracing       PT

**Injections:**    Cortisone-Last Injection: \_\_\_\_\_

Visco.-Last Series completed: \_\_\_\_\_

(Supartz, Hyalgan, Synvisc, Eufflexa, Orthovisc)

**Hip/Lumbar Symptoms:**

Groin Pain       Lateral pain

Pain to Knee       Buttock Pain

Low Back Pain

Radiculopathy (numbness/tingling in toes)

How far down the leg? \_\_\_\_\_

**Injections:**    L/S last completed: \_\_\_\_\_

Hip-       Intra-articular       Lateral

**PAST MEDICAL HISTORY**

List all medical conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any of the following:

- Diabetes Heart Disease Clotting disorder Cancer Hepatitis HIV

**PAST SURGICAL HISTORY**

List all previous surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

List all medications (and dosages)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take any of the following: Coumadin Lovenox Plavix

NSAIDS (i.e. Advil, Motrin, Aleve) Aspirin

Prednisone (Last time?\_\_\_\_\_ How Much?\_\_\_\_\_)

**ALLERGIES**

List all allergies to medications and reaction which occurs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergic Reaction to: Tape/Bandaids Iodine (Contrast/Topical) Chicken/Eggs

**FAMILY HISTORY**

List all illnesses that run in your family: \_\_\_\_\_

Mother's Age \_\_\_\_\_

Father's Age \_\_\_\_\_

Alive       Deceased

Alive       Deceased

Cause of death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Sibling(s) and ages \_\_\_\_\_

**SOCIAL HISTORY**

Do you live alone?  Yes     No      Who lives with you? \_\_\_\_\_

Do you have stairs at home?  Yes     No

What type of work do you do? \_\_\_\_\_

Marital status:       Married     Divorced     Widowed     Single

Number of children: \_\_\_\_\_

Smoke cigarettes:  Yes      Number of packs per day: \_\_\_\_\_

Years smoking: \_\_\_\_\_ Used to, but quit \_\_\_\_\_ months/years ago

No

Alcohol consumption:  Never       Used to, but quit \_\_\_\_\_ years ago

Socially     Daily      \_\_\_\_\_ Times/week    Type of Alcohol: \_\_\_\_\_

History of illicit drug use:  Yes     No    If yes, what kind? \_\_\_\_\_ Last used? \_\_\_\_\_

## **REVIEW OF SYSTEMS**

Please place a check mark next to any symptoms you have had or currently have:

### Constitutional

- Fevers, chills
- Decreased appetite, weight loss
- Night pain that awakens you from deep sleep

### Eyes, Ears, Nose, Throat

- Recent changes in vision
- Glaucoma
- Any metal fragments in your eyes
- Nosebleeds
- Hearing loss
- Loss of balance

### Cardiovascular

- Chest pain
- Palpitations
- Irregular heartbeat
- Shortness of breath
- High blood pressure
- Elevated cholesterol

### Respiratory

- Asthma/wheezing
- Chronic cough
- COPD/emphysema
- Pneumonia or bronchitis
- Tuberculosis
- Lung cancer

### Gastrointestinal

- Upset stomach
- Reflux (GERD)
- Blood in stool
- Dark black, tarry stools
- Yellow jaundice
- Gallbladder problems
- Colon cancer

### Genitourinary

- Burning/pain with urination
- Urinary frequency
- Blood in urine
- History of kidney stones
- Enlarged prostate
- History of prostate cancer

### Musculoskeletal

- Swelling in multiple joints
- Excessive flexibility in joints
- Reflex sympathetic dystrophy (RSD)

### Skin

- Chronic rashes
- Eczema or psoriasis
- Skin cancer or melanoma
- Unusual birthmarks

### Neurological

- History of seizures
- History of stroke/TIA
- Dizziness
- Memory loss

### Psychiatric

- Anxiety
- Depression
- Bipolar disorder
- Schizophrenia

### Endocrine

- Diabetes
- Thyroid problems
- Taking hormone replacement therapy
- Taking prednisone

### Hematologic

- Anemia
- Easy bruising or bleeding problems
- History of blood clots
- History of blood transfusions

*I attest that the above information is correct*

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

*I have reviewed this information with the patient*

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date

**PLEASE STOP HERE**

**PHYSICAL EXAM –To Be Completed by Dr. Zeegen**

**GENERAL EXAM**

**Vitals:**      Height:\_\_\_\_\_      Weight:\_\_\_\_\_

                  Temp:\_\_\_\_\_      BP:\_\_\_\_\_      Pulse:\_\_\_\_\_      RR:\_\_\_\_\_

**General Appearance**

WDN in NAD       Obese

**Orientation:**

A&O x 3

**Skin:**

Normal color, texture and turgor, no rashes noted through trunk, bilateral upper extremities, and bilateral lower extremities

**HEENT:**

- Normocephalic, atraumatic
- Sclera nonicteric
- No nasal discharge
- Oropharynx is clear, dentition is good

**Neck:**

Supple, non-tender w/o LAD, no thyromegaly, no masses

**Cardiac:**

RRR       No murmurs, rubs, gallups

**Lungs:**

CTA bilaterally       Symmetric chest rise

**Abdomen:**

Soft, nontender, nondistended       Bowel sounds present



Leg lengths Equal  
 R > L by \_\_\_\_\_  
 R < L by \_\_\_\_\_

Prior scars: Location: \_\_\_\_\_ Length: \_\_\_\_\_

<b>Knee</b>	<i><b>Right</b></i>	<i><b>Left</b></i>
<b>Alignment:</b>	_____	_____
<b>ROM:</b>	_____	_____
<b>Effusion</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Warmth</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Erythema:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Joint line tenderness:</b>	<input type="checkbox"/> LJLT <input type="checkbox"/> MJLT <input type="checkbox"/> None	<input type="checkbox"/> MJLT <input type="checkbox"/> LJLT <input type="checkbox"/> None
<b>Crepitus:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Pain with PROM:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Ligamentous</b>		
Lachman's	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Ant Drawer	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
MCL	<input type="checkbox"/> Stable <input type="checkbox"/> Med opening	<input type="checkbox"/> Stable <input type="checkbox"/> Med opening
LCL	<input type="checkbox"/> Stable <input type="checkbox"/> Lat opening	<input type="checkbox"/> Stable <input type="checkbox"/> Lat opening
<b>Patella</b>		
Patella grind	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Patella inhibition	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
Hypermobility	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
VMO atrophy	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
<b>Meniscal</b>		
McMurray's	<input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Pos <input type="checkbox"/> Neg

**Neuro:**

<b>Motor</b>	<input type="checkbox"/> 5/5 Q/TA/EHL/GS/P	<input type="checkbox"/> 5/5 Q/TA/EHL/GS/P
	<input type="checkbox"/> Weakness: _____	<input type="checkbox"/> Weakness: _____

**Sensory**

Intact to LT throughout

Intact to LT throughout

Decreased: \_\_\_\_\_

Decreased: \_\_\_\_\_

**DTR's**

2+ T/B/BR

2+ T/B/BR

Neg Hoffman's

Neg Hoffman's

2+ Knee/Ankle

2+ Knee/Ankle

**Vascular**

Palpable DP/PT

Palpable DP/PT

CR < 2 sec all 5 digits

CR < 2 sec all 5 digits

Distal edema

Distal edema



**IMAGING**

**XRAYs:**

**Hip**

**Right**

**Left**

Joint space narrowing:

None Mild Marked

None Mild Marked

Subchondral sclerosis:

Yes No

Yes No

Osteophyte formation:

Yes No

Yes No

AVN

Yes No

Yes No

Other:

Date of exam

\_\_\_\_\_

\_\_\_\_\_

**Knee**

**Right**

**Left**

Alignment:

Neut Varus Valgus

Neut Varus Valgus

Joint space narrowing

None

None

Mild LAT Mild MED

Mild MED Mild LAT

BOB LAT BOB MED

BOB MED BOB LAT

Patellofemoral narrowing

Yes No

Yes No

Other:

Date of exam

\_\_\_\_\_

\_\_\_\_\_

**Spine**

**Cervical**

**Lumbar**

Alignment:

Neut Scoliosis Kyphosis

Neut Scoliosis Kyphosis

Joint space narrowing

None

None

DDD Stenosis

DDD Stenosis

Spondylolisthesis Retro

Spondylolisthesis Retro

Other:

Date of exam

\_\_\_\_\_

\_\_\_\_\_

**MRI:**

- Right*                       *Left*                       Date of Exam: \_\_\_\_\_
- Knee                               Hip                       L/S                       Other: \_\_\_\_\_
- Contrast                       Without Contrast

Findings:

**BONE SCAN:**                       Date of Exam: \_\_\_\_\_

Findings:

- CT SCAN:**     *Right*                       *Left*                       Date of Exam: \_\_\_\_\_
- Knee                               Hip                       L/S                       Other: \_\_\_\_\_
- Contrast                       Without Contrast

Findings:

**PLAN:**