WILLIAM K MONTGOMERY, MD
Knee and Hip Joint Replacement Specialist
New Patient Questionnaire

NAME:	DOB: / / AGE:	DATE:

Your Primary Care Physician: ______________________________ Phone Number: ________________________
Referring Physician: ____________________________________ Phone Number: ________________________

What is the reason for your visit?

Injection(s)	Medication Refill	Discuss Surgery	Joint Replacement	Post-Operative
New Patient	Follow Up	New Injury	Follow Up joint replaced	2ND Opinion
BODY PART:	**RIGHT KNEE**	**LEFT KNEE**	**RIGHT HIP**	**LEFT HIP**

ALLERGY		
☐ **NO KNOWN ALLERGIES**	1.	2.
3.	4.	5.

DO YOU HAVE A LIST OF YOUR MEDICATIONS? PLEASE WRITE "SEE ATTACHED" AND PROVIDE US WITH A COPY

MEDICATIONS			
☐ **NO MEDICATIONS**	1.	2.	3.
4.	5.	6.	7.

Pharmacy Name / crossing streets: ____________________________________ Phone Number: __________________

PERSONAL MEDICAL HISTORY (PLEASE SELECT ALL THAT APPLY)					
Alcoholism	Clotting disorder	Gout	Hypertension	Osteoarthritis	Symptomatic Scoliosis
Anesthetic complications	Club foot	Heart disease	Infectious Disease	Osteoporosis	
Autoimmune disease	Deep vein thrombosis	Hepatitis C	Kidney Disease	Rheumatoid Arthritis	Thyroid Disease
Cancer	Diabetes Mellitus	HIV/AIDS	Liver Disease	Smoking	
Cerebral Palsy	Fractures	Hyperlipidemia	Lung Disease	Stroke	

DO YOU HAVE A LIST OF YOUR SURGERIES? PLEASE WRITE "SEE ATTACHED" AND PROVIDE US WITH A COPY

SURGICAL HISTORY / TYPE OF SURGERY AND OCCURRENCE DATE (APPROXIMATE DATE)		
Ankle Surgery	Hand Surgery	Lumbar Spine Surgery
Back Surgery	Heart Surgery	Shoulder Surgery
Bariatric Surgery	Hip Replacement	Spinal Fusion
Carpal Tunnel Release	Hip Surgery	Spine Surgery
Cervical Spine Surgery	Knee Arthroscopy	Wrist Surgery
Elbow Surgery	Knee replacement	Other:
Foot Surgery	Knee Surgery	

FAMILY HISTORY	ARE THERE ANY ILLNESSES THAT RUN IN THE FAMILY? (PLEASE CIRCLE ALL THAT APPLY)		
☐ Adopted / ☐ Family history unknown			
Anesthesia Problems	Yes	No	Relation: DAD MOM SISTER BROTHER
Arthritis	Yes	No	Relation: DAD MOM SISTER BROTHER
Autoimmune Disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Cancer	Yes	No	Relation: DAD MOM SISTER BROTHER
Clotting Disorder	Yes	No	Relation: DAD MOM SISTER BROTHER
Deep Vein Thrombosis	Yes	No	Relation: DAD MOM SISTER BROTHER
Diabetes	Yes	No	Relation: DAD MOM SISTER BROTHER
Gout	Yes	No	Relation: DAD MOM SISTER BROTHER
Heart Disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Hepatitis	Yes	No	Relation: DAD MOM SISTER BROTHER
HIV	Yes	No	Relation: DAD MOM SISTER BROTHER
Hyperlipidemia	Yes	No	Relation: DAD MOM SISTER BROTHER
Hypertension	Yes	No	Relation: DAD MOM SISTER BROTHER
Kidney Disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Liver Disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Lung disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Osteoporosis	Yes	No	Relation: DAD MOM SISTER BROTHER
Ovarian Cancer	Yes	No	Relation: DAD MOM SISTER BROTHER
Stroke	Yes	No	Relation: DAD MOM SISTER BROTHER
Thyroid disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Other: ________________________			Relation: DAD MOM SISTER BROTHER

SOCIAL HISTORY

Alcohol Use : Yes / Not Currently / Never

How Often do you have a drink containing alcohol?

Never / Monthly or less / 2-4 times a month / 2-3 times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 / 3 or 4 / 5 or 6 / 7 to 9 / 10 or more / rather not answer

How often do you have six or more drinks on one occasion?

Never / less than monthly / monthly / weekly / daily or almost daily / rather not answer

Drinks/Week _____ glasses of wine
_____ Cans of beer
_____ Shots of liquor
_____ standard drinks or equivalent

Sexually Active : Yes / Not Currently / Never

Birth Control / Protection: Abstinence / Coitus interrupts / Condom / Diaphragm / implant / Injections / Inserts / IUD / OCP / Patch / post Menopause / Rhythm / spermicide / sponge / surgical / other-see comments / none

Partners: Female / Male **Comments:** ____

Substance Use : Drug use : Yes / No / Not Currently / Never

Tobacco Use : Yes / Not Currently / Never

Start Date : ______

Quit Date : ______

Types: (Select all that apply)
____Cigarettes ____ Pipe
____ Cigars ____ Electronic Cigarette

Packs/day ______

Years ______

Smokeless Tobacco:

Quit Date : ______

Types:
____ snuff ____ chew

Your Occupation:

Weight: lbs **Height:** ft in

CHIEF COMPLAINT

BODY PART:	RIGHT KNEE	LEFT KNEE	RIGHT HIP	LEFT HIP

Please explain how this condition started:	without cause	fall	injury	other:

When did this condition start?	____day(s)	____week(s)	____month(s)	____year(s)

Where is your pain located? (CIRCLE ALL THAT APPLY)

KNEE : Front of knee , back of the knee , side(s) of the knee , behind your knee cap , side(s) of knee cap
HIP : groin, side of the hip, pain in thigh, pain in buttocks, pain in back of leg

FREQUENCY OF PAIN: (PLEASE CIRCLE IF APPLICABLE)

CONSTANT	INTERMITTENT	PAIN AT NIGHT	PAIN WITH ACTIVITY

PAIN LEVEL AT REST: 0(NO PAIN) – 10 (SEVERE PAIN) (PLEASE CIRCLE)

0	1	2	3	4	5	6	7	8	9	10

PAIN LEVEL WITH ACTIVITY: 0(NO PAIN) – 10 (SEVERE PAIN) (PLEASE CIRCLE)

0	1	2	3	4	5	6	7	8	9	10

What makes pain worse? Prolonged sitting , standing , long walks, kneeling, deep knee bend, stairs, driving, twisting , laying down , other: ____

What relieves your pain? sitting down , NSAID, ice , heat , Tylenol , brace , injection , therapy , cane , pain medication , other: ____

PLEASE DESCRIBE SYMPTOMS: (CIRCLE ALL THAT APPLY)

Swelling	Stiffness	Locking	Instability
Catching	Buckling	Popping	Grinding
Numbness	Tingling	Weakness	Giving Way

PLEASE DESCRIBE YOUR PAIN: (CIRCLE ALL THAT APPLY)

Aching	Dull	Throbbing	Sharp
Shooting	Stabbing	Pulsating	Radiating
Burning			

Have you had to modify your activities? Yes / No **Are you still able to play sports/ exercise?** Yes / No

Does it affect your activities of daily life? Yes / No

Have you had or tried any of the following (please select)?

Yes?	TYPE	Please place date next to treatment if applicable	Effective?
☐	**Anti-inflammatory(NSAID):**	Meloxicam_____ Naproxen_____ Etodolac_____ Celebrex_____Aleve____ Ibuprofen_____ Motrin_____ Naprosyn_____	Yes No
☐	**Analgesic :**	Tylenol_____ Tramadol _____ Narcotics _____	Yes No
☐	**Injections:**	Cortisone_____ Synvisc_____ Monovisc_____ Euflexxa_____ Orthovisc_____	Yes No
☐	**Physical Therapy:**	Date Started:	Yes No
☐	**Brace:**	Unloader Brace Regular Sleeve Hinged Knee Brace	Yes No
☐	**Cane / Walker**		Yes No
☐	**X-Ray (WEIGHTBEARING? Yes / No)**	**MRI / CT**	
☐	**Other:**		

Please list the physician(s) that have treated you previously for this problem:

Physician: ______________________________ Specialty: __________________________ Phone: _________________

******MANDATORY******

Do you have an allergy to Nickel or any metal? YES / NO

Do you have an allergy/reaction to acrylics, wearing artificial nails or dental glue? YES / NO

Do you have an allergy to latex? YES / NO

Are you currently on any blood thinners? YES / NO **if so, which one ? _____________________________**

Do you have any issues in taking anti-inflammatories (NSAIDs)? YES / NO **IF YES, REASON: ________________________**

REVIEW OF SYSTEMS:	Are you currently having, or have you had problems in the past year (select all that apply):			
Constitutional	**Head/Ear/Nose/Throat**	**EYES**	**Respiratory**	**Cardiovascular**
Fever	Ear pain	Blindness	Shortness of Breath	Chest Pain
Irritability	Hearing loss	Double Vision	Sleep disturbance d/t breathing	Palpitations
Night Sweats	Ringing in ears	Vision disturbance		
Unexpected weight change	Trouble swallowing			
None	***None***	***None***	***None***	***None***
Gastrointestinal	**Genitourinary**	**Musculoskeletal**	**Skin**	**Neurological**
Abdominal Pain	Incontinence	Arthralgia (joint pain)	Wound	Dizziness
Bowel incontinence	Decreased libido	Gout	Rash	Vertigo
Constipation	Decreased urine volume	Joint swelling		Seizures
Diarrhea	Voiding frequency	Muscle spasm		Numbness
Nausea	Hesitancy	Myalgia's (muscle pain)		Headaches
		Muscle weakness		Concentration difficulty
		Falls		Speech difficulty
		Paresthesia's		
None	***None***	***None***	***None***	***None***
Endocrine/Heme	**Psychiatric**			
Cold intolerance	Agitation			
Heat intolerance	Behavior problem			
Bleeding problem	Decreased concentration			
Bruise/bleed easily	Depression			
	Anxiety			
	Memory Loss			
	Sleep Disturbance			
None	***None***			

- **E-Mail :** ____
  to sign up for my chart