WILLIAM K MONTGOMERY, MD

Knee and Hip Joint Replacement Specialist
New Patient Questionnaire

NAME:	**DOB: / /** **AGE:**

Your Primary Care Physician: ______________________________ Phone Number: __________________________

Referring Physician: ______________________________________ Phone Number: __________________________

Are you a previous patient of OR have had surgery with Dr. Montgomery? **YES / NO**

Is this the first time you visit with Dr. Montgomery? **YES / NO**

RIGHT HANDED / LEFT HANDED / AMBIDEXTROUS (circle one)

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: ____________________

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	Hand	Lumbar Spine
Back	Heart	Shoulder
Bariatric	Hip Replacement	Spinal Fusion
Carpal Tunnel Release	Hip	Spine
Cervical Spine	Knee Arthroscopy	Wrist
Elbow	Knee replacement	Other:
Foot	Knee	

PERSONAL MEDICAL HISTORY (PLEASE SELECT ALL THAT APPLY)				
Alcoholism	Cerebral Palsy	Gout	Infectious Disease	Rheumatoid Arthritis
Anesthetic complications	Deep Vein Thrombosis	Heart disease	Kidney Disease	Smoking
Autoimmune disease	Diabetes Mellitus	High Cholesterol	Osteoarthritis	Thyroid Disease
Cancer	Fractures	High blood pressure	Osteoporosis	

FAMILY HISTORY — ARE THERE ANY ILLNESSES THAT RUN IN THE FAMILY? (PLEASE CIRCLE ALL THAT APPLY)

Illness			Relation
Anesthesia Problems	Yes	No	Relation: DAD MOM SISTER BROTHER
Arthritis	Yes	No	Relation: DAD MOM SISTER BROTHER
Cancer	Yes	No	Relation: DAD MOM SISTER BROTHER
Clotting Disorder	Yes	No	Relation: DAD MOM SISTER BROTHER
Diabetes	Yes	No	Relation: DAD MOM SISTER BROTHER
Deep Vein Thrombosis	Yes	No	Relation: DAD MOM SISTER BROTHER
Gout	Yes	No	Relation: DAD MOM SISTER BROTHER
Heart Disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Hyperlipidemia	Yes	No	Relation: DAD MOM SISTER BROTHER
Hypertension	Yes	No	Relation: DAD MOM SISTER BROTHER
Thyroid disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Lung disease	Yes	No	Relation: DAD MOM SISTER BROTHER
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Ovarian Cancer	Yes	No	Relation: DAD MOM SISTER BROTHER
Hepatitis	Yes	No	Relation: DAD MOM SISTER BROTHER
HIV	Yes	No	Relation: DAD MOM SISTER BROTHER
Liver Disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Autoimmune Disease	Yes	No	Relation: DAD MOM SISTER BROTHER
Kidney Stones	Yes	No	Relation: DAD MOM SISTER BROTHER
Stroke	Yes	No	Relation: DAD MOM SISTER BROTHER
Other: ________________________			Relation: DAD MOM SISTER BROTHER

SOCIAL HISTORY

Do you consume alcohol? Yes / No	___ glasses of wine ___ cans of beer ___ shots of liquor
Are you a tobacco user? Yes / No Quit Date: ______________ **Are you Smokeless Tobacco user?** Yes / No	Types: (Select all that apply) ____Cigarettes ____ Pipe ____ Cigars ____ Electronic Cigarette
Height: ft in **Weight:** lbs	**Your Occupation:**

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

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

None	None	

CHIEF COMPLAINT:

RIGHT KNEE	LEFT KNEE	RIGHT HIP	LEFT HIP

What is the reason for your visit?

Injection(s)	Medication Refill	Discuss Surgery	Joint Replacement
New Patient	Follow Up	New Injury	Post-Operative
Follow Up joint replaced	2ND Opinion		

Please explain how this condition started:

When did this condition start?

without cause	fall	injury	other:
____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

PLEASE DESCRIBE SYMPTOMS: (PLEASE CIRCLE ALL THAT APPLY)

Swelling	Stiffness	Locking	Instability	Catching	Giving way	Weakness	Buckling
Numbness	Tingling	Other:					

Does anything make the pain worse? ____

Does anything make the pain better? ____

Have you had to modify your activities? Yes / No **Are you still able to play sports/ exercise?** 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
	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 **Does it upset your stomach?** YES / NO

Baylor Scott & White
ORTHOPEDIC ASSOCIATES OF DALLAS
A member of HealthTexas Provider Network

WKM Established Patient Survey

Date:	**DOB:**	**Patient Name:**	
Is this the first time you see Dr. Montgomery? YES / NO			
If you answered **NO** to previous questions, you may skip this question!			
How long has it been since your last visit?______[ ] Days [ ] Weeks [ ] Months			**Date of Surgery (if post op) :**

PERTINENT INFORMATION REQUIRED (PLEASE PROVIDE OF LIST OF MEDICATIONS IF AVAILABLE

Please list any **Changes to Medical History:**

Please list any **NEW Medications:**

Please list any **NEW Allergies:**

SOCIAL HISTORY	
Do you consume alcohol? Yes / No	___ glasses of wine ___ cans of beer ___ shots of liquor
Are you a tobacco user? Yes / No Quit Date: _____________ **Are you Smokeless Tobacco user?** Yes / No	Types: (Select all that apply) ____Cigarettes ____ Pipe ____ Cigars ____ Electronic Cigarette
Height: ft in **Weight:** lbs	**Your Occupation:**

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
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Bruise/bleed easily	Depression			
	Anxiety			
	Memory Loss			
	Sleep Disturbance			
None	***None***			

- **E-Mail :** ______________________________________
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Bleeding problem	Decreased concentration			
Bruise/bleed easily	Depression			
	Anxiety			
	Memory Loss			
	Sleep Disturbance			

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

None	None	

Follow Up Survey

Since your last visit are you: [ ] Better [ ] Worse [ ] Same

A) On a scale of 0-100%, **how much better** are you now? __________ %

B) On a scale of 0-10, 10 being the worst pain,

   a. What is your pain today?__________

   b. What is your pain with activity?__________

C) How do you describe your pain? [ ] Mild [ ] Moderate [ ] Severe [ ] Extremely Severe

D) What has been done for you **since your last visit**? (use check boxes below)

Treatment Type	**Has this helped?**	
[ ] Surgery	[ ] Yes	[ ] No
[ ] Anti-Inflammatories	[ ] Yes	[ ] No
[ ] Narcotics	[ ] Yes	[ ] No
[ ] Brace	[ ] Yes	[ ] No
[ ] Physical Therapy	[ ] Yes	[ ] No
[ ] Injection	[ ] Yes	[ ] No

INTERVAL HISTORY

Since your last visit, have you:

Felt any **NEW**	[ ] Numbness	[ ] Tingling	[ ] Swelling	[ ] Weakness	[ ] None
Developed **NEW**	[ ] Pain	[ ] Symptoms			[ ] None
Started or Stopped Smoking?	[ ] Yes	[ ] No			

******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 **Does it upset your stomach?** YES / NO

Patient Signature: ___________________________________