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? **Is this the first time you visit with Dr. Montgomery ? Yes / No**

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

Substance Use : **Drug use :**

Yes / No / Not Currently / Never

Tobacco Use : Yes / Not Currently / Never **Types: (Select all that apply)** ____Cigarettes ____ Pipe

Start Date : ______ **Quit Date :** ______ ____ Cigars ____ E-Cigarette - Packs/day _____Years _____

Smokeless Tobacco: Yes / Not Currently / Never **Quit Date :** ____ Types: ____ snuff ____ chew

Weight: lbs

Height: ft in

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 / Vertigo
Bowel incontinence	Decreased libido	Gout / Joint swelling	Rash	Seizures
Constipation	Decreased urine volume	Muscle spasm		Numbness
Diarrhea	Voiding frequency	Myalgia’s (muscle pain)		Headaches
Nausea	Hesitancy	Muscle weakness		Concentration difficulty
		Falls / Paresthesia’s		Speech difficulty
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

CHIEF COMPLAINT

BODY PART:	**RIGHT KNEE**	**LEFT KNEE**	**RIGHT HIP**	**LEFT HIP**

Please explain how this condition started:

without cause	fall	injury	gradual onset	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 , Nothing , 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_____ **Date Started NSAID :** Ibuprofen_____ Motrin_____ Naprosyn_____		Yes No
☐	**Analgesic :** Tylenol_____ Tramadol _____ Narcotics _____ **Date Started :**		Yes No
☐	**Injections:** Cortisone_____ Synvisc_____ Monovisc_____ Euflexxa_____ Orthovisc_____ **Date last injection was administered :**		Yes No
☐	**Physical Therapy:** **Home Exercise program :** **Date Started:**		Yes No
☐	**Brace:** Unloader Brace Regular Sleeve Hinged Knee Brace		Yes No
☐	**Cane / Walker**		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:** ________________________