William K. Montgomery, MD /*Sarah E Hamilton, NP*
Knee & Hip Joint Replacement Specialist
New Patient/New Complaint Questionnaire

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

NAME:	DOB: / / AGE:	HEIGHT: WEIGHT:

Primary Care Physician: _____ **Who referred you? / How did you find us?** _____

Body Part: Right Knee | Left Knee | Right Hip | Left Hip **Are you:** New Patient | Follow Up | New Injury

Reason for Visit: Follow Up joint replaced | Discuss Surgery- Joint Replacement | 2ND Opinion

HOW did this condition start? _____ **WHEN did condition start?** _____

WHERE IS THE PAIN LOCATED? (CIRCLE ALL THAT APPLY)

KNEE: Front, back, side(s), behind knee cap, around knee cap	HIP: groin, side of hip, thigh, buttocks, back of leg

FREQUENCY OF PAIN: (PLEASE CIRCLE IF APPLICABLE)

CONSTANT	INTERMITTENT	PAIN AT NIGHT	PAIN WITH ACTIVITY	THE MORE YOU DO, MORE IT HURTS

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? Long sitting, standing, long walks, kneeling, deep knee bend, stairs, driving, twisting, laying down.

What relieves pain? Rest, NSAID, ice, heat, Tylenol, topical, brace, injection, therapy, cane, pain medication, Nothing

PLEASE DESCRIBE SYMPTOMS: (CIRCLE ALL THAT APPLY)				PLEASE DESCRIBE YOUR PAIN: (CIRCLE ALL THAT APPLY)				
Swelling	Stiffness	Locking	Instability	Aching	Dull	Throbbing	Sharp	Shooting
Catching	Buckling	Popping	Grinding	Stabbing	Pulsating	Radiating	Burning	Numbing
Numbness	Tingling	Weakness	Giving Way	Tingling	Tight band	Boring	Crushing	

Have you modified activities? _____ **Can you play sports/ exercise?** _____ **Does it affect activities of daily life?** _____

Yes?	TYPE OF TREATMENT Please place date next to treatment if applicable	Effective?
☐	**Anti-inflammatory (NSAID):** Meloxicam_____ Naproxen_____ Etodolac_____ Celebrex_____Aleve____ ***Date Started NSAID:*** Ibuprofen_____ Motrin_____ Naprosyn_____ Voltaren_____	Yes No
☐	**Analgesic:** Tylenol_____ Tramadol _____ Narcotics _____ Topical_____ ***Date Started:***	Yes No
☐	**Injections**: Cortisone_____ Synvisc_____ Monovisc_____ Euflexxa_____ Orthovisc_____ ***Date last injection was administered:***	Yes No
☐	**Physical Therapy:** Yes / No **Home Exercise program:** Yes / No **Water therapy:** Yes / No **Exercise Handout:** Yes / No **Routine Exercise:** Yes / No **Chiropractor:** Yes / No ***Date Started:***	Yes No
☐	**Brace:** Unloader Brace Regular Sleeve Hinged Knee Brace	Yes No
☐	**cane / walker / wheelchair / crutches**	Yes No
☐	**WEIGHTBEARING X-RAYS / MRI / CT** ☐ **Other:**	

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

Do you have an allergy to NICKEL or ANY METAL? YES / NO **Do you have an allergy to LATEX?** YES / NO

Do you have an allergy/reaction to ACRYLICS, wearing ARTIFICIAL NAILS, or DENTAL GLUE? YES / NO

Are you currently on any PRESCRIPTION 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	**Musculoskeletal**	**Neurological**	**Skin**	**Gastrointestinal**
Activity change	Arthralgia / Joint swelling	Balance issues / Dizziness	Abnormal color change	Acid reflux / Bloating
Appetite change	Neck pain / Back pain	Coordination issues	Dryness / Itching / Rash	Swallowing problems
Chills	Gait Issues / Vertigo	Facial asymmetry	Flushing	Abdominal pain
Chronic pain	Muscle cramps	Focal weakness	Hair change / Nail changes	Anorexia
Daytime sleepiness	Myalgia	Dysphasia	Skin lesion	Nausea / Vomiting
Diaphoresis	Stiff joints	Numbness	Wound healing issues	Bright red hematemesis

*****E-Mail:*** _____ ***FOR PORTAL***

PATIENT ASSESSMENT AND TREATMENT OUTCOMES *(MUST COMPLETE THIS QUESTIONNAIRE* PART 1

1) How much pain do you have in your hip or knee?

HIP		KNEE
R L	No Pain	R L
R L	**Slight**, occasional, no compromise in activity	R L
R L	**Mild**, effects ordinary activity, pain after stairs or unusual activity, use Tylenol	R L
R L	**Moderate**, tolerable, limit activities, use of anti-inflammatory medication	R L
R L	**Marked**, serious limitations, continual	R L
R L	**Severe** or totally disabled	R L

2) When does your hip or knee pain bother you?

HIP		KNEE
R L	No Pain	R L
R L	Pain with standing	R L
R L	Pain with first steps which goes away	R L
R L	Pain only after long walks	R L
R L	Pain with all walking activity	R L
R L	Pain at all times	R L

3) How often does hip or knee pain limit your activities?

HIP		KNEE
R L	Never	R L
R L	1-3 times a month	R L
R L	About once a week	R L
R L	Several days a week	R L
R L	Daily	R L

4) How often does stiffness, limited motion or weakness in your hip or knee limit your activities?

HIP		KNEE
R L	Never	R L
R L	1-3 times a month	R L
R L	About once a week	R L
R L	Several days a week	R L
R L	Daily	R L

5) How much does your hip or knee limit your ability to do sports or physical recreation?

{ } No limitations
{ } Slightly limits me
{ } Moderately limits me
{ } Greatly limits me
{ } Totally limits me

6) How often has your hip or your knee interfered with your ability to get together with friends or relatives?

{ } All of the time
{ } Most of the time
{ } Some of the time
{ } None of the time

7) How much does your hip or knee limit your ability to work?

HIP		KNEE
R L	No limitations	R L
R L	Slightly limits me	R L
R L	Moderately limits me	R L
R L	Greatly limits me	R L
R L	Totally limits me	R L
{ }	Not working for other reasons	

8) Work capacity for the past three months:

{ } Retired
{ } 25%
{ } 50%
{ } 75%
{ } 100%
{ } Works through the pain

9) What level of activity are you routinely doing?

{ } Bedridden or confined to a wheelchair, need assisted care
{ } Sedentary - minimum capacity for walking or other activity, low level activities of daily living (stairs, carrying, lifting, stooping)
{ } Semi-sedentary - white collar job, bench work, light housekeeping, indoor activities of daily living (stairs, carrying, lifting, stooping)
{ } Outdoor activities: occasional low stress sports, (golf, swimming, biking)
{ } Moderate manual labor.
{ } Heavy manual labor, high stress sports (racquet sports, basketball, baseball, skiing, tennis, running)

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PATIENT ASSESSMENT AND TREATMENT OUTCOMES *(MUST COMPLETE THIS QUESTIONNAIRE)* PART 2

10) Do you need support when walking?

{ } Yes { } No

If yes, what kind?

{ } Cane
{ } Walker
{ } Unloader brace
{ } Wheelchair

11) I experience PAIN at what distance:

{ } 1 mile or greater
{ } 6-10 blocks or > 1/2 to < 1 mile
{ } 1-5 blocks or 1/4 to 1/2 mile
{ } 1 block
{ } Less than1 block

12) I experience PAIN at what time after getting up to stand or walk:

{ } 31 - 60 minutes
{ } 11 - 30 minutes
{ } 2 - 10 minutes
{ } Less than 2 minutes

13) How do you climb up stairs? (Answer only if you are able to walk.)

{ } Normally { } Need 1 rail
{ } Need 2 rails { } Unable to climb stairs

14) How much do you limp when you don't use support?

{ } No limp { } Slight limp
{ } Moderate limp { } Severe limp

15) How difficult is it for you to put on your shoes and socks?

{ } No trouble
{ } Able, but with difficulty
{ } Extremely difficult
{ } Unable

16) How do you go down stairs?

{ } Normally, no rails
{ } Need 1 rail
{ } Hip or knee creates instability or balance issues

17) How does your hip or knee affect your ability to get in and out of a car?

{ } Do it with ease
{ } With difficulty
{ } Unable

18) How difficult is it for you to go from sitting to standing?

{ } Can stand up from chair without arms
{ } Must use arms to stand up from chair
{ } Unable to stand up

19) Does your hip or knee pain cause:

{ } Sense of grinding
{ } Instability or giving way
{ } Falls

20) Does your hip or knee interfere with your sleep cycle?

{ } Difficulty falling asleep
{ } Pain or discomfort awakens you from sleep
{ } No effect on sleep

21) Conditions other than current problem which impair ambulation (select all that apply).

{ } Back
{ } Foot/ankle
{ } Lungs
{ } Heart
{ } Neurologic (stroke, paralysis)
{ } Psychological
{ } Other

22) Activities you want to do but can't because of your hip or knee (select all that apply).

{ } No limits	{ } Golf	{ } Skiing
{ } Baseball	{ } Hiking	{ } Stairs
{ } Softball	{ } Jogging	{ } Stooping
{ } Basketball	{ } Lawn mowing	{ } Swimming
{ } Biking	{ } Lifting	{ } Tennis
{ } Carrying	{ } Sex	{ } Walking
{ } Gardening	{ } Skating	{ } Other

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STOP HERE IF YOU PERFORMED E-CHECK-IN ON MYBSWHEALTH PORTAL

ALLERGIES

☐ 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 –(IF YOU HAVE A LIST OF MEDICATIONS, PLEASE PROVIDE US WITH A COPY)

☐ NO MEDICATIONS	1.	2.	3.
4.	5.	6.	7.

Pharmacy Name / crossing streets: _____ Phone Number: _____

PERSONAL MEDICAL HISTORY (PLEASE CIRCLE 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	Other:
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 / Foot Surgery	Heart Surgery	Knee replacement
Bariatric Surgery	Hip Surgery / Arthroscopy	Shoulder Surgery
Carpal Tunnel Release	Hip Replacement	Spine Surgery / Spinal Fusion
Elbow / Hand / Wrist Surgery	Knee Surgery / Arthroscopy	Other

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

☐ **Adopted** ☐ **Family history unknown** Other: _____

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

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

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

Tobacco Use : Yes / Not Currently / Never **Types: (Select all that apply)** ____Cigarettes ____ Pipe ____ Cigars ____ E-Cigarette
Start Date : _____ **Quit Date :** _____ Packs/day _____Years _____

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