RYAN CONE, MD
HIP AND KNEE REPLACEMENT

PEACHTREE ORTHOPEDICS

New Patient Questionnaire

PATIENT INFORMATION

Name:	Date of birth:	Visit date:

How would you like Dr. Cone to address you?
E.g. for John Smith: Mr. Smith, John, Jim

Who sent you to come see us?
PCP, friend, Internet, call center, other. . .

Who is your Primary Care Provider?

What are you hoping to get out of your visit with Dr. Cone?

JOINT PAIN QUESTIONNAIRE

Where is your pain located? *If not listed below, describe here:*

☐ Left knee ☐ Right knee ☐ Left hip ☐ Right hip

For *knee pain*, please answer the following:

Where is it located?

☐ Medial side
Towards other knee
☐ Under knee cap
☐ Shin
☐ Lateral side
Away from other knee
☐ Back of knee
☐ All over

For *hip pain*, please answer the following:

Where is it located?

☐ Groin
☐ Side of hip
☐ To the knee
☐ Buttock
☐ Thigh
☐ Past the knee

Rate your knee stiffness when you wake up: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

How long have you had this pain?
☐ < 6 months ☐ 6-12 months ☐ >1 year ☐ >5 years

Is your pain...
☐ Getting worse
☐ Staying the same
☐ Getting better
☐ Constant
☐ Frequent
☐ Once in a while

How would you rate your pain from 0 - 10, with 10 being the worst pain of your life:

Circle a number: 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain?
☐ Sharp ☐ Aching ☐ Throbbing ☐ Burning ☐ Electric shock

Have you experienced any of the following?
☐ Stiffness ☐ Swelling
☐ Numbness ☐ Weakness

Do you have a limp?
☐ None ☐ Minimal
☐ Moderate ☐ Severe

Do you use an assistive device?
☐ None ☐ Cane ☐ Walker ☐ Wheelchair

In the last week, how much pain have you had during the following activities:

Please check a selection ✔	None	Mild	Moderate	Severe	Extreme
Twisting/pivoting					
Straightening hip or knee fully					
Going up or down stairs					
Walking on an uneven surface					
Standing upright					

In the last week, what effect has your painful joint had on the following activities?

Please check a selection ✔	None	Mild	Moderate	Severe	Extreme
Sitting					
Rising from sitting					
Bending to floor, picking up an object					

Have you tried any of the following?
☐ Advil/Aleve ☐ Tylenol ☐ Aspirin
☐ Meloxicam ☐ Celebrex ☐ Tramadol
☐ Opiod - *Norco, Vicodin, etc.*

Have you had injections into the joint?
☐ None ☐ Yes, steroid/cortisone
☐ Yes, gel - Synvisc, GelOne, etc.
☐ Yes, other:

Have you participated in...
☐ Formal physical therapy ☐ Self-directed exercise program ☐ Other regular exercise:

Have you ever had surgery before?
☐ Never
☐ Yes, joint that Dr. Cone is evaluating:
☐ Yes, elsewhere in body:

MEDICAL HISTORY

Height:

Weight:

Have you ever been diagnosed with:

☐ Heart attack
☐ Stroke
☐ Diabetes, last A1C:
☐ Blood clot
☐ Sleep apnea
☐ CPAP/BiPAP
☐ Kidney problem
☐ Liver problem
☐ Lung problem
☐ MRSA infection
☐ Other:

Do you have any allergies?
☐ No ☐ Yes:

Do you have any sensitivities to metals?
☐ No ☐ Yes

Current medications: *Attach list as needed*

In the last two years, have you had a fall?
☐ No ☐ Yes

If yes, did this fall result in an injury?
☐ No ☐ Yes

SOCIAL HISTORY

What kind of work do you do?
☐ Mom/Dad ☐ Manual labor ☐ Desk job ☐ Retired ☐ Other:

Who lives at home with you?

Who is your support person if you need surgery?

Do you use any nicotine products?
☐ No ☐ Yes, include type and frequency:

Do you regularly use any illicit substances?
☐ No ☐ Yes:

How often do you have an alcoholic drink?
☐ Never ☐ Monthly or less
☐ 2-4 times a month
☐ Weekly, days per week:

If you do drink alcohol:
1. When you do drink, how many drinks do you typically have in one sitting?
2. How many times in the last year have you had more than 8 drinks (6 drinks for women) in one sitting?

FAMILY HISTORY

To you knowledge, has anyone in your family experienced any of the following:
☐ Problems with anesthesia ☐ Hereditary bleeding or blood clot disorders
☐ Other hereditary disorders that we should know about: