



David J. Mayman MD
Joint Replacement and Sports Medicine
Medical History

Presenting Problem:

Shoulder Hip Knee Other:

Did symptoms start with an injury: Yes No

Date of onset of symptoms:

Have you had any previous imaging?

X-ray CT Scan MRI
yes no yes no yes no
Date: Address of Facility:

List any previous operations:

Two horizontal lines for listing previous operations.

List all previous or ongoing medical issues:

Two horizontal lines for listing medical issues.

List all current medications:

Three horizontal lines for listing current medications.

List all allergies to medications:

Three horizontal lines for listing allergies to medications.

Social History:

Alcohol consumption: Drinks per week
Smoking history: never quit 1 pack per day

Height: Weight:

Review of Systems: I have a history of (please check all that apply)

Cardiac Disease High Blood Pressure Valvular disease Asthma Pulmonary disease Gastro-esophageal reflux Gastric Ulcer Duodenal Ulcer Ulcerative colitis Crohn's disease Other Bowel disease Other Gastric Disease
Glaucoma Other Eye Disease Peripheral Vascular Disease Back Pain Skin Problems Neurologic disorders Rheumatoid Arthritis Diverticulitis Ankylosing Spondylitis Lupus