

# David J. Mayman MD

Joint Replacement and Sports Medicine  
New Patient Registration and Demographics



## Personal Information:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Gender: M F  
\_\_\_\_\_ Telephone #: Home \_\_\_\_\_  
Email Address: \_\_\_\_\_ Office \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Cell \_\_\_\_\_

## Emergency Contact Information:

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Pharmacy Tel: \_\_\_\_\_

## Marital Status:

Single  Married  Separated  Divorced  Widowed

## Employment or School Information:

Employer or School: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  Full-Time  Part-Time  
\_\_\_\_\_  Retired  Student  
Employer's Tel. #: \_\_\_\_\_

## Medical Insurance:

Insurance Company Name: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Insurance company tel. #: \_\_\_\_\_

## Physician Information:

Primary Care Physician: \_\_\_\_\_  
Tel. #: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Would you like a copy of your notes  
sent to your PCP?  Yes  No  
Referring Physician: \_\_\_\_\_  
Would you like a copy of your notes  
sent to your Referring Physician?  Yes  No

## Guarantor / Policy Holder if Not Patient:

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
\_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Occupation: \_\_\_\_\_  
\_\_\_\_\_  Full-time  Part-time  
 Retired  Student  
Employer Telephone Number: \_\_\_\_\_

Assignment and Release of information statement: I certify that the information given by me is correct. I understand that this information is entered into Dr. Mayman's computer database which exists on the hospital network. I hereby authorize sharing of this and future information with hospital affiliated physicians, government agencies, and / or insurance carriers. I hereby authorize payments to be made directly to Dr. Mayman.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# New Patient Questionnaire

## Adult Reconstruction & Joint Replacement



Height:	Weight:	Age:
---------	---------	------

**Chief Complaint (select all that apply)**

Location/Laterality:

<b>Hip</b>	Left	Right	Both
<b>Knee</b>	Left	Right	Both

Other location: \_\_\_\_\_

Please describe your symptoms:

Throbbing	Radiating	Stiffness	Catching/Locking
Swelling	Sharp	Dull	Instability
Other:			

**Current Pain Level (no pain 0 – 10 highest):**

Hip – Right Side

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Hip – Left Side

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Knee – Right Side

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Knee – Left Side

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

When did this condition start? \_\_\_\_\_

Please explain how this condition started: \_\_\_\_\_

Does anything make the pain better? \_\_\_\_\_

Does anything make the pain worse? \_\_\_\_\_

Please specify where the pain is located in your knee and/or hip:

Knee	Front	Back	Inside	Outside	Other:
------	-------	------	--------	---------	--------

Hip	Groin	Thigh	Outside	Buttocks	Other:
-----	-------	-------	---------	----------	--------

Have you EVER tried any prior conservative treatment?	Yes	No	How Long?
<b>Acupuncture or Holistic Remedies</b>			
<b>Arthroscopic Surgery</b>			
<b>Brace/Cane/Crutches/Walker</b>			
<b>Cortisone Injections</b>			
<b>Dietary Supplements</b>			
<b>Gel Injections</b>			
<b>NSAIDS (eg: Ibuprofen, Aspirin, Naproxen, Celebrex, Voltaren)</b>			
<b>Narcotics</b>			
<b>Physical Therapy</b>			
<b>Weight Loss</b>			

Are you currently on any blood thinners? \_\_\_\_\_

Do you currently have a MRSA Infection? Yes No

Have you ever had any problems with anesthesia? Yes No Problem: \_\_\_\_\_

Have you ever had complications from prior surgery? Yes No Problem: \_\_\_\_\_

**Hip Functional Assessment (skip if you are seeing the surgeon about your Knee):**

How much pain do you have when walking?

None	Mild	Moderate	Severe
------	------	----------	--------

To what extent are you able to put on shoes and socks?

Easy	Difficult	Unable
------	-----------	--------

Do you have a limp?

None	Slight	Moderate	Severe
------	--------	----------	--------

Describe the extent to which you are able to sit:

Any chair, 1 hour	High chair, 30 minutes	Unable
-------------------	------------------------	--------

How do you climb stairs?

Normally	With banister	With assistance	Unable
----------	---------------	-----------------	--------

What distance are you able to walk?

Unlimited	6 blocks	2-3 blocks	< 1 block	Bed to chair
-----------	----------	------------	-----------	--------------

Are you able to use public transportation?

Yes	No
-----	----

**Knee Functional Assessment (skip if you are seeing the surgeon about your Hip):**

How much pain do you have when walking?

None	Mild	Moderate	Severe
------	------	----------	--------

How much pain does your knee have when going up the stairs?

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

How much pain does your knee cause when you are at rest?

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

How do you get out of a chair?

Normally	Armrest to push	With assistance	Unable
----------	-----------------	-----------------	--------

How do you go upstairs?

Normal up and down	Normal up/down with rail
Up and down with rail	Up with rail/unable to go down

How does your knee affect your walking ability?

Unlimited	> 10 blocks	5-10 blocks	< 5 blocks	< 1 block	Unable
-----------	-------------	-------------	------------	-----------	--------

**Immunizations and Falls Screening:**

Have you received the pneumonia vaccine? Yes No

If yes, date? \_\_\_\_\_ If not, why? \_\_\_\_\_

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No  
If yes, date? \_\_\_\_\_

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

**Medical and Family History**

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Open Wounds/Ulcers	Yes	
Arrhythmia (Irregular heartbeat)	Yes		Osteoarthritis	Yes	
Asthma	Yes		Osteoporosis	Yes	
Bleeding Problems	Yes		Peripheral Vascular Disease	Yes	
Blood Clots (DVT)	Yes		Pneumonia	Yes	
Cancer	Yes		Psychiatric Illness (Depression)	Yes	
Diabetes	Yes		Pulmonary Embolus	Yes	
Heart Attack	Yes		Reflex Sympathetic Dystrophy	Yes	
Heart Disease	Yes		Reflux	Yes	
High Blood Pressure	Yes		Rheumatoid Arthritis	Yes	
High Cholesterol	Yes		Seizures	Yes	
Infection	Yes		Stroke	Yes	
Kidney Disorders	Yes		Ulcers	Yes	
Lung Disease	Yes		Other:	Yes	

## Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

## Social History

1. Are you a tobacco user? Yes No
2. Do you consume alcohol? Yes No  
 If yes (women): more than 7 drinks per week, or more than 3 drinks per occasion? Yes No
- If yes (men): more than 14 drinks per week, or more than 4 drinks per occasion? Yes No

## Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	Hematologic	Respiratory	Skin
Chills	Easy bruising/bleeding	Increased sputum	Ulcers
Fever	DVT	Coughing up blood	Nodules
Sleep difficulty		Shortness of breath	Lesions
Fatigue			Hives
Night sweats			Rash
Weight Change			Jaundice
None	None	None	None

ENT	Cardiovascular	Endocrine	Musculoskeletal
Double vision	Chest pain	Cold intolerance	Joint pain
Headaches	Edema	Heat intolerance	Arthritis
Hearing loss	Palpitations	Excessive thirst	Muscle pain
Cataracts	Poor circulation	Excessive hunger	Joint swelling
Glaucoma			Muscle cramps
Dry eyes			Muscle weakness
Sore throat			Joint stiffness
None	None	None	None

Gastrointestinal	Genitourinary	Neurological	Psychiatric
Abdominal pain	Bladder incontinence	Tingling	Depression
Trouble swallowing	Blood in urine	Dizziness	Anxiety
Heartburn	Urinary difficulty	Weakness	Mood swings
Nausea	Painful urination	Loss of balance	
Vomiting	Urinary retention	Numbness	
Constipation	Urinary urgency	Difficulty walking	
None	None	None	None

Eyes	Environmental Allergies	Other
Dryness	Pollen	
Discharge	Dust Mites	
Itching	Pets/Animals	
Pain	Mold/Mildew	
Redness		
None	None	

## VR-12 Health Survey

**Instructions:** This questionnaire asks for your views about your health. Answer every question by marking the answer as indicated. If you are unsure how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
-----------	-----------	------	------	------

2. Does your health now limit:

a. Moderate activities such as moving a table, pushing a vacuum, bowling or playing golf?

Yes, limited a lot	Yes, limited a little	No, not limited at all
--------------------	-----------------------	------------------------

b. Climbing several flights of stairs?

Yes, limited a lot	Yes, limited a little	No, not limited at all
--------------------	-----------------------	------------------------

3. During the past 4 weeks, has your physical health resulted in:

a. You accomplished less than you would like

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------

b. Limited in the **kind** of work or other activities

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------

4. During the past 4 weeks, as a result of any emotional problems (such as feeling depressed or anxious):

a. Have you **accomplished less** than you would like

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------

b. Have you not completed work or other activities as **carefully** as usual

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------

5. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and house work)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
------------	--------------	------------	-------------	-----------

6. During the past 4 weeks, have you felt calm and peaceful

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time
-----------------	------------------	----------------------	------------------	--------------------	------------------

7. During the past 4 weeks, did you have a lot of energy?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time
-----------------	------------------	----------------------	------------------	--------------------	------------------

8. During the past 4 weeks, have you felt downhearted and blue?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time
-----------------	------------------	----------------------	------------------	--------------------	------------------

9. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities ( such as visiting friends, relatives, etc...)

None of the time	A little of the time	Some of the time	Most of the time	All of the time
------------------	----------------------	------------------	------------------	-----------------

10. Compared to 1 year ago, how would you rate your **physical health** in general now?

Much better	Slightly better	About the same	Slightly worse	Much worse
-------------	-----------------	----------------	----------------	------------

11. Compared to 1 year ago, how would you rate your **emotional problems** (such as feeling anxious, depressed or irritable) **now**?

Much better	Slightly better	About the same	Slightly worse	Much worse
-------------	-----------------	----------------	----------------	------------

**KOOS, JR. Knee Survey (skip if you are seeing the surgeon about your Hip):**

Instructions: This survey asks for you view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.

Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

**Which Knee:**

Left	Right	Both
------	-------	------

**Stiffness:** Amount of joint stiffness you have experienced the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

**Pain:** What amount of knee pain have you experienced the last week during the following activities?

2. Twisting/pivoting on your knee:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

3. Straightening knee fully:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

4. Going up or down stairs:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

5. Standing upright:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

**Function, daily living:** The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experience in the last week due to your knee.

6. Rising from sitting:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

7. Bending to floor/pick up an object:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

**HOOS, JR. Hip Survey (skip if you are seeing the surgeon about your Knee):**

Instructions: This survey asks for you view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.

Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

**Which Hip:**

Left	Right	Both
------	-------	------

**Pain:** What amount of hip pain have you experienced the last week during the following activities?

1. Going up or down stairs:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

2. Walking on an uneven surface:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

**Function, daily living:** The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experience in the last week due to your hip.

3. Rising from sitting:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

4. Bending to floor/pick up an object:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

5. Lying in bed (turning over, maintaining hip position):

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

6. Sitting:

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

**Pre-operative Return-to Work Survey**

1. What is your current employment status?

- a. Employed, full time
- b. Employed, part time
- c. Unemployed, due to hip/knee
- d. Unemployed due to reasons unrelated to hip/knee
- e. Retired
- f. Other

2. If currently employed, how would you describe the physical demands of your job?

- a. Sedentary/Light activity: spend most of the day sitting (e.g. Desk job)
- b. Moderate activity: spend most of the day on your feet (e.g teacher/salesperson)
- c. High Activity: spend a good part of the day doing some physical activity (e.g. waitress, mailman)
- d. Strenuous: spends most of the day doing heavy physical activity (e.g. construction worker)

3. If currently employed, at what level of productivity on 0-100% scale are you currently functioning in the workplace because of your hip/knee?

4. If currently employed, how many days in the last six months did you miss work because or your hip/knee?





**Agreement to Participate: Witnessing and Signature**

To be in this registry, you or your legal representative must sign this page. By signing this page, you are voluntarily agreeing to be in this registry at HSS.

Before signing, you should be sure of the following:

- You have read all of the information in this “Informed Consent to Participate in Research Registry” form (or had it read to you).
- You have discussed the implications of your being in the registry with your HSS physician.
- You have had the chance to ask questions about the registry, and your questions were answered.
- If you did not understand any of the answers to your questions, you asked your HSS physician or a staff member to explain them to you.
- You have had time to think about the information and decide whether or not to be in the registry.

If you decide to be in this registry:

- You are expected to provide the information needed by the doctor, nurses, or other staff members for the registry.
- You may freely choose to stop being in the registry at any time.

By signing here, you are voluntarily agreeing to be in this registry.

You must be given a signed copy of this informed consent form to keep for yourself.

Print Name of Participant	Signature of Participant	Date
Print Name of Person Obtaining Consent	Signature of Person Obtaining Consent	Date

By signing above, the person obtaining informed consent confirms that: (i) he/she has discussed the registry with the participant named above (including explaining the registry to, and reviewing this informed consent form with, the participant); (ii) this informed consent form was left with the participant and he/she was given time to consider whether or not to be in the registry; (iii) the participant was provided with an opportunity to ask questions about the registry and have them answered; and (iv) the participant agreed to take part in the registry and signed this informed consent form prior to his/her participation in the registry.

\_\_\_\_\_

As an HSS representative, please sign here to indicate that you have given a signed copy of this informed consent form to the participant

Form 10e - Informed Consent to Participate In Research Registry





## ePrescribing Notice to Patients

ePrescribing is submitting a prescription to your pharmacy through the internet. The ability to ePrescribe is an important element in improving the quality of patient care by reducing medication errors and enhancing patient safety.

Through ePrescribing your physician may also obtain **medication history** (information about the medications you are already taking or have taken within the past year) when applicable for the purpose of coordinating your treatment. Having an accurate list of your medications is critical to providing good medical care.

YES, I allow my physician to obtain **medication history** (check box)

NO, I do not allow my physician to obtain **medication history** (check box)

**Note: while you may not allow us to obtain your medication history, we may still submit an ePrescription. Alternatively, we may also provide a paper prescription.**

If I choose not to allow my physician to access my medication history through ePrescribing, I understand that my physician may not be aware of all medications prescribed by others. Therefore, I am solely responsible for informing my physician about medications I have been prescribed by other physicians or prescribers. I acknowledge and accept any and all risks, including the risk of adverse drug events, associated with my physician not having access to my medication history through ePrescribing.

By signing below, I confirm that I have read and understand all of the above, that I have had the chance to ask questions and all of my questions have been answered to my satisfaction, and that I am eligible to sign this form on behalf of myself/the patient.

**Patient Name** \_\_\_\_\_  
(Print)

**Signature of Patient/Parent/Guardian/** \_\_\_\_\_  
**Health Care Agent/Other Surrogate** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Financial Interest Disclosure Form**  
**Medical Staff, Allied Health Professional Staff,**  
**Residents, and Fellows**

David Mayman, MD

As your treating physician and as a member of the Medical Staff of Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with Smith & Nephew, an orthopedics device company, and OrthAlign and Stryker-MAKO Surgical Corp., companies that develop products for surgical navigation technology, whose products I may use, or prescribe, for you in your care at HSS. The following will provide you with information about my financial relationships with these companies:

I perform consulting for and receive compensation from Smith & Nephew as related to computer-assisted surgical navigation products, knee implant design, education, and I serve as a member of the Knee Advisory Board.

I am a consultant for and receive compensation in the form of stock options from OrthAlign, a surgical navigation product company.

I am a consultant for software design and development for Stryker-MAKO Surgical Corp. and provide services as an educational speaker.

**I DO NOT RECEIVE ANY PAYMENTS FROM THESE COMPANIES FOR USE OF THEIR PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.**

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact Mark P. Figgie, MD, Chief of Service, (212-606-1932), the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

Signature \_\_\_\_\_  
Patient/Parent/Guardian/Health Care Agent Date

Print Name \_\_\_\_\_  
Patient/Parent/Guardian/Health Care Agent

Relationship to Patient \_\_\_\_\_

**PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD**

**For Office Use Only: If the patient does not sign this acknowledgment form, record here the good faith efforts made to obtain this acknowledgement.**

\_\_\_\_\_  
\_\_\_\_\_