Michael W. Hartman, MD
Orthopaedic Surgery & Sports Medicine

For Office Use Only: Account # ______________________________

PATIENT MEDICAL HISTORY

Name: ____ **Today's Date:** ____________________

Age: _______________ **DOB** __________________ **Occupation** ____________________

VITALS

Height: _________ **Weight:** ________ **Blood Pressure:** ____________ **Heart Rate:** ______________

CHIEF COMPLAINT

What hurts? ____ ___ **Left** ___ **Right**

HPI

Who referred you? _______________________________ **Name of Family Doctor:** ___________________

When? (Date your symptoms began) ____

Where? (example: home, work) ____

If this was a work-related injury, what was the date of injury? ______________________________

If this was a work-related injury, was the injury reported to your employer? ____Yes ____No

Comments: ____

How did your symptoms start? ____

What are your symptoms? ____

What makes the pain better? ____

What makes the pain worse? ____

On a scale of 1-10, rank your pain (10 is the worst): 1 2 3 4 5 6 7 8 9 10

List the tests you have had done (X-rays, CAT scans, MRI scans, EMGs, etc)

List the treatment you have had for this condition (medication, physical therapy, chiropractic, injections, surgery, etc.)

PAST MEDICAL HISTORY

- **Please check all the boxes below that name the conditions that apply to you.**

___No Past Medical History **___Past Medical History Unchanged Since Last Visit**

Medical Problems			Recent Medical Tests
__ Asthma	__ Heart attack	__ Rheumatoid Arthritis	__ Blood work
__ Cancer	__ High blood pressure	__ Skin disease	__ Bone Scan
__ Depression	__ High cholesterol	__ Stroke	__ CT scan
__ Diabetes	__ Kidney problems	__ Thyroid	__ MRI
__ Drug dependency	__ Lung problems	__ Ulcers	__ EMG
__ Epilepsy	__ Osteoporosis	__ Other:	__ X-ray
__ Gout	__ Prostate problems	__ Other:	__ Other:

Michael W. Hartman, MD
Orthopaedic Surgery & Sports Medicine

For Office Use Only: Account # ______________________

Name: ________________________________ **Today's Date:** ______________

PAST SURGICAL HISTORY

- **Please check all the boxes below that name the conditions that apply to you.**

__ No Past Surgical History __ Past Surgical History Unchanged Since Last Visit

Previous Surgeries	Date	Hospital	Doctor
__ Appendectomy			
__ Cesarean Section			
__ Gallbladder			
__ Heart (open or bypass)			
__ Hysterectomy			
__ Joint surgery (arthroscopic or open) Which joint? ______________			
__ Spine surgery			
__ Tonsillectomy			
__ Other (please list)			

MEDICATIONS

Pharmacy Name: ______________________ **Phone:** ______________

- **List the names of ALL medications that you take (including over-the-counter medicine), the dosage, and the frequency.**

Name of Medication	Dosage	Frequency
Example: **Naprosyn**	**375mg**	**1 tablet twice a day**

(*If needed, continue medications list over page*)

Michael W. Hartman, MD

Orthopaedic Surgery & Sports Medicine

For Office Use Only: Account # ______________________________

Name: ____ **Today's Date:** ____________________

ALLERGIES

__ **No Known Drug Allergies** ___ **Allergies Unchanged Since Last Visit**

- **List the names of ALL drug allergies that you have**

Drug Allergies:

Name of Drug	Describe your reaction when you have taken the drug:

FAMILY MEDICAL HISTORY

- **Please describe below any illnesses found in the patient's blood relatives.**

___ **No Family Medical History** ___ **Medical History Unchanged Since Last Visit**

Illness	Family Member(s)
Arthritis	
Bleeding Condition	
Cancer	
Diabetes	
Heart Disease	
Osteoporosis	
Scoliosis (curvature of the spine)	
Stroke	

SOCIAL HISTORY

- **Please check all the boxes below that apply to you.**

Tobacco : __ Yes __ No Packages per day: ______________________ Years: ______________________

Alcohol: __ Yes __ No Frequency: ____

Michael W. Hartman, MD

Orthopaedic Surgery & Sports Medicine

For Office Use Only: Account # ______________________________

Name: ____ **Today's Date:** ____________________

REVIEW OF SYSTEMS

Have you recently had any of the following problems? Please check all boxes below that apply to you.

Problem		Yes	No	If yes, please explain
1. **Constitutional** (overall)	a. Weight gain			
	b. Weight loss			
	c. Fever			
	d. Chills			
	e. Night sweats			
2. **Eyes**	a. Vision change			
3. **Head, Ears, Nose, Throat**	a. Difficulty hearing			
	b. Hoarseness			
4. **Breast**	a. Breast Masses			
5. **Cardiovascular** (heart)	a. Chest pain			
	b. Irregular heartbeat			
6. **Respiratory** (breathing)	a. Shortness of breath			
7. **Gastrointestinal** (digestion)	a. Stomach ulcers			
	b. Heartburn			
	c. Jaundice			
8. **Genitourinary** (urination)	a. Frequent urination			
	b. Painful urination			
9. **Skin/ Integument**	a. Rash			
	b. Skin problems			
10. **Neurological** (nervous system)	a. Headaches			
	b. Numbness			
11. **Musculoskeletal** (muscles & bones)	a. Joint pain			
	b. Night pain			
12. **Endocrine** (hormones and glands)	a. Fatigue			
13. **Psychiatric** (emotions)	a. Depression			
13. **Hematologic** (blood)	a. Anemia			
	b. Bleeding disorders			
	c. Blood transfusion			

Additional Patient Comments: ____

____

____

Internal Use Only:

1. Reviewed by ____________ *Date:* ____________ *2. Reviewed by* ____________ *Date:* ____________