

Orthopaedic Knee Shoulder & Sports Surgery

Patient Medical History

Michael M. Heckman M.D.,P.A.

Name: _____

Date: _____

B/P: _____ Ht: _____ Wt: _____ Pulse _____

Primary Care/Family Doctor _____

Major Complaint(s) or Injury:

How and when did it happen?

Are there prior injuries to this area(s): ___ Yes ___ No

Is this work related? ___ Yes ___ No If yes, Date of Injury _____

Is this a sport injury? ___ Yes ___ No If so, School Name: _____

Is an attorney involved? ___ Yes ___ No If so, name: _____

Do you smoke? ___ Yes ___ No If so, how many packs a day: _____

Do you drink alcohol? ___ Yes ___ No If so, how often: _____

Do you have a history of drug or alcohol abuse? ___ Yes ___ No

Signature

Date

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Musculoskeletal/Joints

- Muscular Disease
- Arthritis
 - Rheumatoid
 - Degenerative
 - SLE

Metabolic Problems

- Diabetes
- Thyroid

Urinary Problems

- Urination Problems
- Prostate Disease
- Kidney Disease
- Kidney Failure
- Kidney Infection
- Kidney Stones

Cardiovascular Problems

- Angina
- Heart Attack
- Chest Pain
- Mitral Valve Prolapse
- Irregular Heartbeat
- High Blood Pressure
- Shortness of Breath
- Pacemaker

Gastrointestinal Problems

- Stomach Ulcers
- Gallbladder Problems
- Pancreatitis
- Colitis
- Blood in Stool
- Hiatal Hernia
- Liver Disease
- Constipation
- Loss of Bowel Control
- Hepatitis
 - A
 - B
 - C
- Jaundice

Immunological Diseases

- HIV Virus

- AIDS Virus

Neurological Problems

- Headaches
- Migraines
- Seizures
- Epilepsy
- Strokes
- Depression

Bleeding Disorders

- Anemia
- Blood Clots
- Bleeding Problems

Respiratory Problems

- Asthma
- Bronchitis
- COPD
- Emphysema
- Pneumonia
- Tuberculosis

Reproductive System

- Infections
- Herpes
- Venereal Disease

Cancer

- Lung
- Breast
- Colon/Intestinal
- Stomach
- Prostate
- Skin
- Kidney
- Bone
- Other Malignancy

WOMEN Only

- Endometriosis

Are you currently taking birth control?

___ Yes ___ No

Are you currently pregnant?

___ Yes ___ No

Are you currently trying to conceive?

___ Yes ___ No

Signature

Date

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Surgery History-Please indicate ANY surgeries you have had in the past and include Date, Hospital and Procedure. If you can not recall the exact date, then please give us the approximate time frame.

Date

Hospital

Procedure

Please list ALL medications, Nutritional, or Herbal Substances you are currently taking:

Name

Dosage

How Often

Please list any known allergies to medications:

Please List any other Important Medical Information about yourself or members of your family:

Signature

Date

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