The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION
100 Kingsley Lane, Suite 300
Norfolk, VA 23505

NEW PATIENT MEDICAL HISTORY

Date: _____
Chart # _____
Primary Care Physician _____

Patient's Name _____Ref Physician_____
Date of Birth: __/____/____ Age_____Weight _____Height_____Date of last tetanus_____
Problems with anesthesia □ YES □ NO If yes, explain _____
Current Conditions _____

Do you have an allergy to chicken and/or eggs or ever been told you should not receive the flu vaccination? □ YES □ NO

Allergies/Difficulty with Medications	Reaction	□ None	Current Medication	Dosage	□ None
1. _____			1. _____	_____	
2. _____			2. _____	_____	
3. _____			3. _____	_____	
4. _____			4. _____	_____	
5. _____			5. _____	_____	

Please Check All That Apply To You

PERSONAL MEDICAL HISTORY

__ No Illnesses	__ Pneumonia	__ Bladder/Kidney Infection	__Scarlet Fever
__ Diabetes	__ Tuberculosis	__ Arthritis	__ Bleeding Disorders
__ High Blood Pressure	__ Heart Attack or Heart Disease	__ Cancer	__ Intestinal Problems
__ Stroke	__ Ulcers	__ Mental or Nervous Disorder	__ Angina
__ Emphysema	__ Hepatitis	__ Seizures	__ Heart Murmurs/Valve Problems
__ Bronchitis	__ Gallbladder Disease	__ Venereal Disease	__ Other
__ Asthma	__ Pancreatitis	__ AIDS/HIV	__ Specify _____

SOCIAL HISTORY

Do you smoke cigarettes? □ YES □ NO
Do you drink alcohol? □ YES □ NO
Do you take drugs? □ YES □ NO
Marital Status □ Married □ Single □ Divorced □ Separated □ Number of Children _____
Are you □ Right Handed □ Left Handed
How many hours a day do you stand and/or walk while at work? □ 0-1 □ 1-3 □ 3-5 □ 5-8 While at home? □ 1-3 □ 3-5 □ 5-8
Employment: (Type) _____

FAMILY HISTORY (Siblings, parents and children)

			REVIEW DATE	
			Date	Initial
__ No Disease	__ Kidney Disease	__ Other (Specify)_____		
__ Diabetes	__ Arthritis	_____	_____	_____
__ High Blood Pressure	__ Asthma	_____	_____	_____
__ Heart Disease	__ Seizures	_____	_____	_____
__ Cancer	__ Excessive Bleeding	_____	_____	_____
__ Tuberculosis	__Problems with Anesthesia	_____		

Physician's Signature _____
R. Michael Graham, MD, FAAOS

Previous Surgery □ NONE Dates

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months): □ NONE

____ Chest X-ray ____ Stress Test ___ Blood Work ___ EKG

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)

GENERAL □ None
__ Fever
__ Chills
__ Night Sweats

ABDOMEN □ None
__ Nausea
__ Vomiting
__ Pain and/or Difficulty Swallowing
__ Gas
__ Indigestion
__ Abdominal Pain
__ Bloating
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Blood Stools

MUSCULOSKELETAL: □ None
__ Fracture
__ Sprain
__ Strains
__ Dislocations

HEAD □ None
__ Headaches
__ Blackouts
__ Seizures
__ Dizziness
__ Double and/or Blurred Vision
__ Ringing Ears
__ Sinusitis
__ Post Nasal Drip
__ Sore Throat
__ Hoarseness
__ Cold

URINARY □ None
__ Blood in Urine
__ Burning with Urination
__Bladder or Kidney Infection
__ Frequency and/or Difficulty with
__ Starting Urination
__ Difficulty with Leaking Urine
__ Getting Up at Night to Urinate

SKIN □ None
__ Rash
__ Itching
___ Psoriasis
__ Change in or Bleeding of Mole

CHEST □ None
__ Cough
__ Cold
__ Sputum
__ Coughing up Blood
__ Wheezing
__ Shortness of Breath
__ Chest Pain
__ Palpitations
__ Heart Murmur
__ Swelling of Feet
__ Rheumatic Fever

NEUROMUSCULAR □ None
__Joint Stiffness
__ Joint Pain
__ Swelling
__ Back Pain
__ Varicose Veins
__ Night Cramps
__ Bursitis
__ Tendonitis
__ Raynaud's

FEMALE PATIENTS

Do you take Birth Control Pills? □ YES □ NO
If YES, type _____
Do you take PREMARIN or ESTROGEN or other hormone replacements? □ YES □ NO
If YES, type _____
Is there any chance you are pregnant? □ YES □ NO