

*The Orthopaedic Center for*  
**FOOT AND ANKLE RECONSTRUCTION**

150 Kingsley Lane  
 Norfolk, VA 23505

**NEW PATIENT MEDICAL HISTORY**

Date \_\_\_\_\_

Chart # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Ref Physician \_\_\_\_\_

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Date of last tetanus \_\_\_\_\_

Problems with anesthesia?  YES  NO If yes, explain \_\_\_\_\_

Current Complaints \_\_\_\_\_

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 <input type="checkbox"/> None	Current Medication	Dosage <input type="checkbox"/> None
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____
5. _____	_____	5. _____	_____

Please Check All That Apply To You:

PERSONAL MEDICAL HISTORY			
<input type="checkbox"/> No Illnesses	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bladder/ Kidney Infection	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack or Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Intestinal Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Mental or Nervous Disorder	<input type="checkbox"/> Angina
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Murmurs/Valve Problems
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Specify _____

SOCIAL HISTORY			
Do you smoke cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many packs per day?	_____
Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Number of drinks per day	_____ per week
Do you take drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Check all that apply:	<input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Others (specify) _____
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> Number of Children	_____
Are you:	<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed		
How many hours a day do you stand and/or walk while at work?	<input type="checkbox"/> 0-1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-8	While at home?	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-8
Employment: (Type)	_____		

FAMILY HISTORY (Siblings, parents and children)			REVIEW DATE	
<input type="checkbox"/> No Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other (specify) _____	Date	Initial
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	_____	_____	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	_____	_____	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	_____	_____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Excessive Bleeding	_____	_____	_____
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> 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)			
<b>GENERAL:</b> <input type="checkbox"/> None ___Fever ___Chills ___Night Sweats ___Weight Change	<b>HEAD:</b> <input type="checkbox"/> None ___Headaches ___Blackouts ___Seizures ___Dizziness ___Hearing Loss ___Double and/ or Blurred Vision ___Ringing Ears ___Sinusitis ___Post Nasal Drip ___Sore Throat ___Hoarseness ___Cold	<b>CHEST:</b> <input type="checkbox"/> None ___Cough ___Cold ___Sputum ___Coughing up Blood ___Wheezing ___Shortness of Breath ___Chest Pain ___Palpitations ___Heart Murmur ___Swelling of Feet ___Rheumatic Fever	
<b>ABDOMEN:</b> <input type="checkbox"/> None ___Nausea ___Vomiting ___Pain and/ or Difficulty Swallowing ___Gas ___Indigestion ___Abdominal Pain ___Bloating ___Constipation ___Diarrhea ___Hemorrhoids ___Blood Stools	<b>URINARY:</b> <input type="checkbox"/> None ___Blood in Urine ___Burning with Urination ___Bladder or Kidney Infection ___Frequency and/or Difficulty with Starting Urination ___Sense of Full Bladder ___Difficulty with Leaking Urine ___Getting Up at Night to Urine	<b>NEUROMUSCULAR:</b> <input type="checkbox"/> None ___Joint Stiffness ___Joint Pain ___Swelling ___Back Pain ___Varicose Veins ___Night Cramps ___Bursitis ___Tendonitis ___Raynaud's	
<b>MUSCULOSKELETAL:</b> <input type="checkbox"/> None ___Fracture ___Sprain ___Strains ___Dislocations	<b>SKIN:</b> <input type="checkbox"/> None ___Rash ___Itching ___Psoriasis ___Change in or Bleeding of Mole		

**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