Advanced Orthopedics
Nonsurgical & Regenerative Treatments
1658 Pleasure House Rd, Suite 104
Virginia Beach, VA 23455

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)

		Other (Specify)
__ No Disease	__ Kidney Disease	
Diabetes	Arthritis	
High Blood Pressure	Asthma	
		__ _____
Heart Disease	Seizures	
Cancer	Excessive Bleeding	
__ Tuberculosis	__ Problems with Anesthesia	

REVIEW DATE	
Date	Initial

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