FOX VALLEY ORTHOPAEDIC ASSOCIATES, S.C.
ADULT HISTORY FORM

Date _____

Patient Number: _____

Name: _____ DOB: _____AGE: _____GENDER:_____ **HT**_____ **WT**_____

PHARMACY NAME:
PHARMACY ADDRESS:
PHARMACY PHONE #:

MEDICATION /VITAMINS /SUPPLEMENTS/	DOSE	MEDICATION /VITAMINS /SUPPLEMENTS/	DOSE	MEDICATION /VITAMINS /SUPPLEMENTS/	DOSE	MEDICATION /VITAMINS /SUPPLEMENTS/	DOSE

MEDICATION ALLERGIES?: ☐ No ☐ Yes If yes, list medication allergies / reactions

	YES		YES		YES
Seasonal Allergies		**Food Allergies**		**Adhesive/Tape Allergies**	
Environmental Allergies		**Metal Allergies**		**Latex Allergies**	

MEDICAL HISTORY

☐ **No significant medical history.**

	YES		YES		YES	NO
Stroke or TIA		**Depression**		**Cancer**		
Arrhythmias		**Panic Attack/Anxiety**		**Arthritis**		
Heart Attack		**Reflux (GERD)**		**Rheumatoid Arthritis**		
Heart Murmur		**Ulcers**		**Osteoporosis**		
High Blood Pressure		**Hypothyroid**		**Gout**		
High Cholesterol		**Kidney Disease**		**Fibromyalgia**		
DVT or Blood Clot		**Crohn's Disease**		**Pain Management**		
Bleeding Tendencies		**Hepatitis**		**RSD/CRPS (Reflex Sympathetic Dystrophy / Complex Regional Pain Syndrome)**		
Neurological Disorder		**HIV Infection**				
Migraine Headache		**Asthma**				
Epilepsy		**Tuberculosis**		**Have you ever had a Dexascan (bone density test)?**		
Diabetes						
				Urinary loss of control		
				Living will/ adv. directives		

SURGICAL HISTORY

☐ **No history of prior surgery.**

	YES		YES		YES
Brain Surgery		**Thyroid Surgery**		**Prostate Surgery**	
Spine Surgery		**Tonsillectomy/Adenoidectomy**		**Hysterectomy**	
Shoulder Surgery		**Appendectomy**		**Breast Surgery**	
Hand Surgery		**Gallbladder Surgery**		**Mastectomy**	
Wrist Surgery		**Gastric Bypass**		**Cesarean Section**	
Hip Surgery		**Hernia Repair**		**Ever had anesthesia?**	
Knee Surgery		**Coronary Artery Bypass Graft**		**Reaction to anesthetic?**	
Foot Surgery		**Pacemaker Placement**		**Describe**	
Ankle Surgery		**Stent Placement**		**Other**	
Pain Management					

Name: _____ **SOCIAL HISTORY** Patient Number:_____

Occupation: (please list)		Marital / Living Status		Exercise		Alcohol		
			YES		YES			YES
	YES	Single		Never		Never		
Employed		Married		Rarely		1-2x/year		
Unemployed		Lives Alone		1-2x/week		1-2x/month		
Homemaker		Assisted Living		3-4x/week		1-2x/week		
Student		Nursing Home		Daily		Daily		
Retired				Cardio		Smoker	NO	YES
Disabled				Weights		Former Smoker	NO	YES
				Walk		Substance Abuse	NO	YES
						Marijuana use	NO	YES

REVIEW OF SYSTEMS

☐ **No signs or symptoms.**

SYMPTOM	YES	SYMPTOM	YES	SYMPTOM	YES
Weight Loss		Nausea		Do You Worry a Lot?	
Fever		Vomiting		Are You a Nervous Person?	
Chills		Vomiting of Blood		Frequently Unhappy or Depressed?	
Fatigue		Any Change in Bowel Habits		Excessively Thirsty	
Double Vision		Blood in / on Bowel Movements		Excessively Hot or Cold	
Loss of Vision		Use Laxative Regularly		Excessively Sleepy	
Loss of Hearing		Heartburn		More Pale Appearance	
Severe Nose Bleeds		Difficult Urination		Seasonal Allergies/Hayfever	
Hoarseness		Pain or Burning on Urination			
Frequent Sore Throats		Blood in Urine			
Shortness of Breath with Exertion		Frequent Urge to Empty Bladder		OTHER:	
Swelling of Feet or Ankles		Loss of Urine with Laughing, Coughing, etc.			
Sudden Changes in Rate of Heart Beat		Swelling in joints		WOMEN ONLY:	
		Stiffness in joint			
Pain or Pressure in Chest with Exertion		Weakness		Currently pregnant?	
		Frequent Itching			
Awakened at Night Short of Breath		Rashes			
		Skin Cancer			
Chronic Cough		Numbness/Tingling			
Coughing up Blood		Seizures			
Rattling/Wheezing Sounds in Chest		Memory Loss			
		Balance Problems			

FAMILY HISTORY (IMMEDIATE FAMILY)

☐ **No significant family history.**

	Mother		Father		Sister		Brother
	YES		YES		YES		YES
Rheumatoid Arthritis							
Osteoporosis							
Heart Disease							
Diabetes							
Blood Clots / DVT							

Patient Signature:_____ Date:_____

If patient is a minor - Parent or Guardian Signature: _____

FOR CURRENT PATIENTS WHO ARE UPDATING THEIR RECORDS: Have there been any changes since last completing this form? ☐ No ☐ Yes

Patient Signature:_____ Date:_____

If patient is a minor - Parent or Guardian Signature: _____

Reviewed by physician/provider and documented in Electronic Health Record