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

DATE_____________

NAME_________________________________ DOB__________ AGE_____ SEX M F PATIENT#___________

PHARMACY/ ADDRESS / CITY ____ HT_______ WT_______

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	

☐ No significant medical history.

MEDICAL HISTORY

	YES		YES		YES
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		Other:	
Diabetes					

☐ No history of prior surgery.

SURGICAL HISTORY

	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					

SOCIAL HISTORY

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

PLEASE COMPLETE OTHER SIDE

REVISED 05/18

FOX VALLEY ORTHOPAEDIC ASSOCIATES, S.C.

HEALTH HISTORY FORM

NAME:________________________ TODAY'S DATE________________________

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			
Swelling of Feet or Ankles		Loss of Urine with Laughing, Coughing, etc.			
Sudden Changes in Rate of Heart Beat		Swelling in joints		OTHER:	
		Stiffness in joint			
Pain or Pressure in Chest with Exertion		Weakness		WOMEN ONLY:	
		Frequent Itching		Currently pregnant?	
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							
Other							

Patient Signature:________________________ Date:________________

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

Reviewed by physician/provider and documented in Electronic Health Record

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