

**FOX VALLEY ORTHOPAEDIC ASSOCIATES, S.C.**

NAME: \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**FAMILY HISTORY**

Member	Alive	Deceased	Age	Health status or cause of death
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

**REVIEW OF SYSTEMS**

SYMPTOM	NO	YES	SYMPTOM	NO	YES
Weight Loss			Difficult Urination		
Fever and/or Chills			Pain or Burning on Urination		
Fatigue			Blood in Urine		
Double Vision			Frequent Urge to Empty Bladder		
Loss of Vision			Loss of Urine when Laughing, Coughing, etc.		
Loss of Hearing			Swelling in joints		
Severe Nose Bleeds			Morning stiffness		
Hoarseness			Weakness		
Frequent Sore Throats			Frequent Itching		
Shortness of Breath with Exertion			Rashes		
Swelling of Feet or Ankles			Skin Cancer		
Sudden Changes in Rate of Heart Beat			Numbness/Tingling		
Pain or Pressure in Chest with Exertion			Seizures		
Awakened at Night Short of Breath			Memory Loss		
Asthma			Balance Problems		
Chronic Cough			Do You Worry a Lot?		
Coughing up Blood			Are You a Nervous Person?		
Rattling or Wheezing Sounds in Chest			Are You Frequently Unhappy or Depressed?		
Frequent Chest or Bronchial Infections			Excessively Thirsty, Hot, Cold, Sleepy		
Nausea or Vomiting			Loss of Energy		
Vomiting of Blood			More Pale Appearance		
Any Change in Bowel Habits			Hay Fever		
Blood in or on Bowel Movements			Seasonal Allergies		
Use Laxative Regularly			WOMEN ONLY: Are you pregnant?		
Heartburn			Date of last menstrual period:		

**COMMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>RETURNING PATIENTS ONLY:</b> Have there been any changes since last completing this form? <input type="checkbox"/> No <input type="checkbox"/> Yes  If yes, please complete a new form. Patient Signature: _____ Date: _____
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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ M.D. Date: \_\_\_\_\_

**FOX VALLEY ORTHOPAEDIC ASSOCIATES, S.C.**

NAME: \_\_\_\_\_ ACCT # \_\_\_\_\_

PHARMACY / CITY \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

SEX      M      F      DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

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

**ALLERGIES:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**ILLNESSES**

	NO	YES		NO	YES		NO	YES
Stroke or TIA			Depression			Pneumonia		
Heart Attack			Panic Attack			Asthma		
Heart Murmur			Epilepsy			Tuberculosis		
High Blood Pressure			Reflux (GERD)			Diabetes		
High Cholesterol			Ulcers			Cancer		
DVT or Blood Clot			Hypothyroid			Enlarged Prostate		
Bleeding Tendencies			Kidney Disease			HIV		
Anemia			Kidney Stones			Rheumatoid Arthritis		
Hepatitis			Gall Stones			Arthritis/DJD		

**PAST MEDICAL HISTORY**

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia?     No     Yes  
 Have any problems with anesthesia?     No     Yes    Describe: \_\_\_\_\_

**SOCIAL HISTORY**

Employed (occupation \_\_\_\_\_)     Homemaker     Student     Retired     Nursing Home/Assisted Living

Single     Married     Divorced     Separated     Widowed

Children?     No     Yes # \_\_\_\_\_      Do you live alone?     No     Yes

Exercise?     Daily     Weekly     Monthly     Rarely     Never    What type of exercise? \_\_\_\_\_

History of substance abuse?     No     Yes      What? \_\_\_\_\_

Smoke currently?     No     Yes    \_\_\_Packs/day for \_\_\_years.      Previously smoked    \_\_\_Packs/day for \_\_\_years.

Quit smoking?     This year     >1 year     >5 years     >10 years

Drink alcohol     Daily     1-2 x/week     1-2 x/month     1-2 x/year

PLEASE COMPLETE OTHER SIDE

REVISED 07/02/09