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

Date: ________________
Patient Number: ________________

Name: ____

DOB: ________________ AGE: _________ GENDER: ______________ **HT**_________ **WT**_________

PHARMACY NAME: ____
PHARMACY ADDRESS: ____
PHARMACY PHONE #: ____
Reason for Visit:____

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
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			
Diabetes					
Urinary Loss of Control?					
Have you ever had a DXA Scan (bone density test)?		Living will or Advanced Directives in Place?			

Fall Risk Assessment: Age 65 and older	YES	NO
Two or more falls within the past year?		
Any Fall with injury in the past year?		

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
		Single		Never		Never		
	YES	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
						Marijuana use	NO	YES

REVIEW OF SYSTEMS

☐ **No signs or symptoms.**

SYMPTOM	YES	SYMPTOM	YES	SYMPTOM	YES
Unexpected Weight Changes		Chest pain		Hair Loss	
Fever		Leg Swelling		Bluish/whitish discoloration of fingers and toes with cold temperatures or stress	
Night Sweats		Inflammation of the lining of the heart		Skin Rash in Sun	
Fatigue		Fluid around the heart		Skin Thickening	
Dry Mouth		Abdominal Pain		Skin Tightening	
Oral Ulcers		Acid Reflux		Headaches	
Nasal Ulcers		Blood in Stool		Burning or Tingling or Numbness of Hands and Feet	
Pain in Jaw when Chewing		Constipation		Decreased Concentration	
Nose Bleeds		Diarrhea		Anxiety/Nervousness	
Hearing Changes		Difficulty Swallowing		Sleep Disturbances	
Scalp Tenderness		Blood in Urine		Women Only:	
Eye Dryness		Protein in Urine			
Irritation or pain with redness of The eyes		Swollen lymph nodes		Currently Pregnant?	
		Easy Bruising			
Visual Changes		Easy Bleeding			
		Blood clots in veins			
Shortness of Breath		Blood clots in arteries			
		Blood clots in lungs			
Chronic Cough		History of Miscarriage			
Coughing up Blood		Rash			
Inflammation of lining of lungs (Pleurisy)		Psoriasis			
		Ulcer			

Do you have an active Diagnosis of Depression? If yes, check the checkbox below and skip to family history. If not please answer questions 1 and 2 below.

☐ **YES, I have an active diagnosis and am currently being treated for depression.**

Over the last 2 weeks, how often have you been bothered By any of the following problems? **(Circle Number that applies)**	Not at all		Several Days		More than half the days		Nearly every day
1. Little interest or pleasure in doing things?	0		1		2		3
2. Feeling down, depressed, or hopeless?	0		1		2		3
3. Total Score from questions 1 and 2: ____________							

Name: **Patient Number:**

FAMILY HISTORY (IMMEDIATE FAMILY)

☐ **No significant family history.**

	Mother		Father		Sister		Brother
	YES		YES		YES		YES
Rheumatoid Arthritis							
Osteoporosis							
Lupus							
Gout							
Sjogren's Syndrome							
Scleroderma							

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