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		Fall Risk Assessment: Age 65 and older	YES	NO
Diabetes						
Urinary Loss of Control?				Two or more falls within the past year?		
Have you ever had a DXA Scan (bone density test)?		Living will or Advanced Directives in Place?		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
	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			

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							
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