FOX VALLEY ORTHOPAEDIC ASSOCIATES, S.C.

PATIENT 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			Worry a lot?		
Coughing up Blood			Have difficulty with attention?		
Rattling or Wheezing Sounds in Chest			Overactive?		
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					
Heartburn					

FEMALES ONLY

Are you pregnant?	☐ NO	☐ YES	Date of last menstrual period:
Are periods regular?	☐ NO	☐ YES	Age at first period:

COMMENTS

_____

_____

_____

RETURNING PATIENTS ONLY: Have there been any changes since last completing this form? ☐ No ☐ Yes

If yes, please complete a new form. Parent Signature:_____**Date:**_____

Parent or Guardian Signature:_____ **Date:**_____

Reviewed By:_____**M.D. Date:**_____

FOX VALLEY ORTHOPAEDIC ASSOCIATES, S.C.

ACCT #_____

PEDIATRIC HISTORY FORM

PATIENT NAME:_____ TODAY'S DATE_____

PHARMACY / CITY_____

SEX M F DATE OF BIRTH_____ AGE_____ HEIGHT_____ WEIGHT_____

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

ALLERGIES TO MEDICATIONS (LIST)	REACTION
Are you allergic to latex? ☐ No ☐ Yes	

ILLNESSES

	NO	YES		NO	YES		NO	YES
Heart Murmur			Reflux (GERD)			Diabetes		
Bleeding Tendencies			Kidney Disease			Cancer		
Anemia			Pneumonia			HIV		
Hepatitis			Asthma			Rheumatoid Arthritis		
Epilepsy/Seizures			Tuberculosis			Ever on a ventilator?		
						Ever admitted to ICU?		

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Has patient ever had general anesthesia? ☐ No ☐ Yes

Have any problems with anesthesia? ☐ No ☐ Yes Describe:_____

Has family had problems with anesthesia? ☐ No ☐ Yes Describe:_____

Family history of malignant hyperthermia? ☐ No ☐ Yes Describe:_____

BIRTH HISTORY

Born at _____ weeks gestation. ☐ Vaginal ☐ C-Section - why? _____

☐ Vertex (head first) ☐ Breech (buttocks first) ☐ Went home with Mom in _____ days. If no, why?_____

_____

Problems with pregnancy?_____

_____

Age began rolling over_____Sitting up_____Walking_____

Date of last tetanus_____ Are immunizations up to date? ☐ No ☐ Yes

PLEASE COMPLETE OTHER SIDE

REVISED 07/02/09