MUIR ORTHOPAEDIC SPECIALISTS
A MEDICAL GROUP, INC.

Patient Medical History Form

Please complete the following information

Name

Date of Birth

Past Medical History

Hospital Admission(s)

Surgical History

Serious Injuries (fractures, sprains, etc.)

Additional Information

Illnesses

- ☐ Tuberculosis
- ☐ Mental Illness
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Allergies
- ☐ Migraines
- ☐ Spinal Disorder
- ☐ Diabetes
- ☐ Arthritis
- ☐ Cancer

please specify

Other Illnesses

Family History

- ☐ Tuberculosis
- ☐ Mental Illness
- ☐ Gout
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Allergies
- ☐ Migraines
- ☐ Spinal Disorder
- ☐ Diabetes
- ☐ Arthritis
- ☐ Cancer

please specify

Other Illnesses

Personal / Social History

Height **Weight**

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Number of Children Children at Home

Are you currently pregnant? ◯ Yes ◯ No

Current Medications

Allergies

Do you smoke? ◯ Yes ◯ No Quantity used per day

Do you consume alcohol? ◯ Yes ◯ No Quantity consumed

Do you use recreational drugs? ◯ Yes ◯ No Description of use

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Patient Medical History Form

Please check all that apply

Name

Date of Birth

Review of Systems

Constitutional

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Other

Cardiovascular

- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Irregular Heartbeat/palpitations
- ☐ Leg Swelling
- ☐ Fainting/Loss of Consciousness

Other

Integumentary/Skin

- ☐ Contact Alllergy
- ☐ Itchy Skin
- ☐ Rash
- ☐ Skin Infection
- ☐ Skin Lesion

Other

Metabolic/Endocrine

- ☐ Cold Intolerant
- ☐ Heat Intolerant
- ☐ Hair Loss

Other

Head, Eye, Ear, Nose & Throat

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Trouble Swallowing
- ☐ Ear Drainage
- ☐ Facial Pain
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nasal Congestion
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Vision Loss
- ☐ Ear Drainage

Other

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Black Stools
- ☐ Diarrhea
- ☐ Jaundice
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

Other

Neurological

- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Poor Coordination
- ☐ Memory Loss
- ☐ Constipation
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors

Other

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Other

Hematologic

- ☐ Bleeding
- ☐ Bruising

Other

Respiratory

- ☐ Chest Pain
- ☐ Cough
- ☐ Dyspnea/Shortness of Breath
- ☐ Recent Infection
- ☐ TB Exposure
- ☐ Wheezing

Other

Genitourinary

- ☐ Dysuria/Painful Urination
- ☐ Frequent Urination
- ☐ Hematuria/Blood in Urine
- ☐ Urge Incontinence
- ☐ Urinary Incontinence

Other

Musculoskeletal

Immunological

- ☐ Asthma
- ☐ Bee Sting Allergy
- ☐ Contact Dermatitis
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

Other