Muir Orthopaedic Specialists
Specialized • Innovative • Compassionate

HEALTH HISTORY

Please complete the following information for review by your provider.

Name: ______________________ Birth Date: ____/____/______ Age: ______

Height: ______ Weight: ______ Sex: ○ M ○ F Dominant Hand: ○ Right ○ Left

Referring Provider: ______________________ Occupation: ______________________

Patient Medical History (mark all that apply)

__Acid Reflux
__AIDS/HIV
__Arthritis
__Bleeding Disorder
__Cancer
Type & Year______
____

__Depression
__Diabetes
__Drug Abuse
__DVT (Blood Clot)
__Fibromyalgia
__Gout
__Atrial Fibrillation

__Hepatitis
__High Blood Pressure
__Irregular Heart Beat
__Kidney Disease
__Lung Disease
__COPD
__Seizure Disorder

__Osteoporosis
__Sleep Apnea
__Liver Disease
__Thyroid Disease
__Heart Attack
__Stroke
__Asthma

__Anemia
__Enlarged Prostate
__Heart Disease
__Other:
____
____

Previous Surgeries & Date(s): ☐ ***NONE***

1.	4.
2.	5.
3.	6.

Is Injury Work Related ? __Yes __No **If yes, have you filed a work comp claim?** __Yes __No

Family Medical History (Mark if your immediate family members (mom, dad, siblings) have any of these conditions)

__Alcoholism __Bleeding __Diabetes __Heart Disease __Kidney Disease __Seizures
__Arthritis __Cancer __Gout __High Blood Pressure __Mental Illness __Stroke

Social History

Do you exercise regularly? __Yes __No Describe: ______________________

Tobacco Use? __Yes __No Type: ____________ Amount per day ______ # of years used: ____

Alcohol Consumption? __Yes __No If yes, __Daily __Weekly __Monthly __Occasionally __Socially

Recreational/Drug Usage: __Yes __No Type/Amount/How Often: ______________________

Allergies : __None __Yes, list →

Latex Allergy/Sensitivity? __Yes __No
Metal Allergy? __Yes __No
Shellfish Allergy? __Yes __No

Medication/Food	Allergic Reaction

Preferred Pharmacy Name: ______________________
Pharmacy Address: ______________________
Pharmacy Phone Number: ______________________

Patient Signature: ______________________ Date: ____________

MUIR ORTHOPAEDIC SPECIALISTS
SPECIALIZED • INNOVATIVE • COMPASSIONATE

Patient Name:____________________

Date of Birth:____________________

HEALTH HISTORY

Review of Systems

Review of Systems *(recent or current conditions only)*

CONSTITUTIONAL:
- ☐ ***NONE***
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Chills

CARDIOVASCULAR:
- ☐ ***NONE***
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Irregular Heartbeat/ Palpitation
- ☐ Leg Swelling
- ☐ Fainting

INTEGUMENTARY:
- ☐ ***NONE***
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin Infections
- ☐ Skin Lesion
- ☐ Contact Allergy

METABOLIC/ ENDOCRINE:
- ☐ ***NONE***
- ☐ Hair Loss
- ☐ Heat Intolerant
- ☐ Cold Intolerant

HEAD, EYE, EAR, NOSE & THROAT:
- ☐ ***NONE***
- ☐ Blurred / Double vision
- ☐ Difficulty Swallowing
- ☐ Ear Drainage
- ☐ Facial Pain
- ☐ Headache
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Vision Loss

GASTROINTESTINAL:
- ☐ ***NONE***
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Frequent Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

NEUROLOGICAL:
- ☐ ***NONE***
- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Poor Coordination
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Seizures
- ☐ Tremors
- ☐ Tingling

PSYCHIATRIC:
- ☐ ***NONE***
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

HEMATOLOGIC:
- ☐ ***NONE***
- ☐ Bleeding
- ☐ Bruising

REPRODUCTIVE:
- ☐ ***NONE***
- ☐ Pregnant

RESPIRATORY:
- ☐ ***NONE***
- ☐ Cough
- ☐ Dyspnea (Difficulty Breathing)
- ☐ Recent Infections
- ☐ Known TB Exposure
- ☐ Wheezing
- ☐ Shortness of Breath

GENITOURINARY:
- ☐ ***NONE***
- ☐ Dysuria (Painful Urination)
- ☐ Frequent Urination
- ☐ Hematuria (Blood in Urine)
- ☐ Urge Incontinence
- ☐ Urinary Incontinence

IMMUNOLOGICAL:
- ☐ ***NONE***
- ☐ Asthma
- ☐ Contact Dermatitis
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Bee Sting Allergies