COMPREHENSIVE
PROSTHETICS & ORTHOTICS

PATIENT MEDICAL HISTORY

DATE: _____

PATIENT INFORMATION

NAME	ACCOUNT NUMBER

WHO REFERRED YOU TO OUR OFFICE?

☐ Physician ☐ Hospital ☐ Physical Therapist ☐ Family ☐ Friend ☐ Other

REFERRING PHYSICIAN	PHONE NUMBER	DATE OF LAST VISIT
	( ) -	

PRIMARY CARE PHYSICIAN	PHONE NUMBER	DATE OF LAST VISIT
	( ) -	

PHYSICAL THERAPIST / OCCUPATIONAL THERAPIST	PHONE NUMBER	DATE OF LAST VISIT
	( ) -	

REASON FOR YOUR VISIT TODAY / DIAGNOSIS IF KNOWN

Have you received any orthotics or prosthetics within the past 5 years? ☐ Yes ☐ No

If yes, list item, provider where received and date:

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
		( ) -

GENERAL OVERALL HEALTH	CURRENT HEIGHT	CURRENT WEIGHT	SHOE SIZE
☐ Excellent ☐ Good ☐ Fair ☐ Poor			

ACTIVITY LEVELS

☐ Highly Active ☐ Active ☐ Medium ☐ Low

ALLERGIES

Do you have a Latex Allergy? ☐ Yes ☐ No

Do you have any other Allergies? (please list) ☐ Yes ☐ No

MEDICAL CONDITIONS (please check all that apply and make notes in other items of concern)

Are you a diabetic? ☐ Yes ☐ No If Yes, ☐ Type I ☐ Type II

Are you Insulin Dependent? ☐ Yes ☐ No

☐ Heart Problems	☐ Hepatitis A or B	☐ Vision Problems	☐ Pacemaker / Defibrillator
☐ Hypertension	☐ Hepatitis C	☐ Parkinson's Disease	☐ Seizure Disorder
☐ Vascular Disease	☐ HIV Positive	☐ Alzheimer Disease	☐ Hearing Loss
☐ Stroke	☐ Rheumatoid Arthritis	☐ Psychiatric Problems	☐ Currently Pregnant
☐ Diabetes	☐ Obesity	☐ Alcoholism	☐ MRSA
☐ Kidney Disease	☐ Osteoarthritis		
☐ Osteoporosis	☐ Pulmonary Disease (TB)		

Other items of concern:

MEDICATIONS (please list below the Medications you are currently taking)

_____ _____

_____ _____