**PATIENT MEDICAL HISTORY**

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ACCOUNT NUMBER</th>
</tr>
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<tbody>
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</tbody>
</table>

**WHO REFERRED YOU TO OUR OFFICE?**

- □ Physician
- □ Hospital
- □ Physical Therapist
- □ Family
- □ Friend
- □ Other

**REFERRING PHYSICIAN**

<table>
<thead>
<tr>
<th>PHONE NUMBER</th>
<th>DATE OF LAST VISIT</th>
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**PRIMARY CARE PHYSICIAN**

<table>
<thead>
<tr>
<th>PHONE NUMBER</th>
<th>DATE OF LAST VISIT</th>
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**PHYSICAL THERAPIST / OCCUPATIONAL THERAPIST**

<table>
<thead>
<tr>
<th>PHONE NUMBER</th>
<th>DATE OF LAST VISIT</th>
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**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**

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP TO PATIENT</th>
<th>PHONE NUMBER</th>
</tr>
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</table>

**GENERAL OVERALL HEALTH**

<table>
<thead>
<tr>
<th>CURRENT HEIGHT</th>
<th>CURRENT WEIGHT</th>
<th>SHOE SIZE</th>
<th>□ Excellent  □ Good  □ Fair  □ Poor</th>
</tr>
</thead>
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</table>

**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)

- □ Heart Problems
- □ Hypertension
- □ Vascular Disease
- □ Stroke
- □ Diabetes
- □ Kidney Disease
- □ Osteoporosis
- □ Other items of concern:

  □ Hepatitis A or B
  □ Hepatitis C
  □ HIV Positive
  □ Rheumatoid Arthritis
  □ Obesity
  □ Osteoarthritis
  □ Pulmonary Disease (TB)
  □ Vision Problems
  □ Parkinson’s Disease
  □ Alzheimer Disease
  □ Psychiatric Problems
  □ Alcoholism
  □ Pacemaker / Defibrillator
  □ Seizure Disorder
  □ Hearing Loss
  □ Currently Pregnant
  □ MRSA

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

________________________________________
________________________________________
________________________________________