MEDICAL CENTER
ORTHOTICS & PROSTHETICS

Name:_____ DOB:_____Age:_____

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

Date of last physical: _____

Disability and Device History

Cause of Injury/ Amputation: _____Date of Amputation:_____
Are you currently using a device? **( )**Y **( )**N
Previous Provider Name:_____Previous Prosthtist Name:_____
Current Weight:_____

Family and Social

Are you currently employed? **( )** Y **( )**N If Yes, where_____
What type of work do/did you do? _____ How long have/did you work there? _____
Do you live alone? **( )**Y **( )**N
Children or dependents: **( )**Y **( )**N Current ages (list)_____Residing with you **( )** Y **( )** N
Where do you live? **( )** Private House, **( )** Nursing facility_____
Do you have family nearby: **( )**Y **( )**N (Please describe) _____

Current or past medical conditions (check all that apply)

( ) Asthma/COPD/ respiratory **( )** Cardiovascular (heart attack, cholesterol, angina)
( ) Back Pain **( )** Osteoarthritis **( )** Rheumatoid Arthritis
( ) Hypertension **( )** Diabetes **( )** Cancer
( ) Kidney Disease **( )** Dialysis. Please indicate schedule_____
( ) Stroke**,** CVA **( )** Osteoporosis **( )** Epilepsy or seizure disorder
( ) GI disease **( )** Head trauma **( )** HIV/AIDS
( ) Liver problems **( )** Pancreatic problems **( )** Thyroid disease
( ) Nutritional deficiency **( )** Auto immune disease **( )** Psychiatric Condition
( ) Allergies- Please describe_____
( ) Other- Please describe)_____

Please list your current Medications: (if applicable)

_____

_____

Alcohol and Tobacco Use History

Do you Smoke? **( )** Y **( )**N Have you smoked in the past? **( )** Y **( )**N
If Yes to smoking currently or in the past, how many per day _____for how many years_____

Do you Drink Alcohol? **( ) Y ( )N** If Yes, how often do you drink?_____ How much?_____

Signature: _____ **Date**_____