MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Have you experienced any of the following?

- ☐ Heart Problems
- ☐ Hypertension
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Hepatitis A or B
- ☐ Hepatitis C
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pulmonary Disease
- ☐ Vision Problems
- ☐ Parkinson Disease
- ☐ Alzheimer Disease
- ☐ Psychiatric Problems
- ☐ Alcoholism
- ☐ MRSA/STAPH Infection

List any other conditions that might affect your treatment:

_____

Medications you are currently taking that might affect your treatment:

_____

Current Height **Current Weight** **Shoe Size**

_____ **ft** _____ **in** _____ **lbs** _____

Amputations

Date	Cause	Surgeon	Additional Info.

Traumas

Date	Cause	Surgeon	Additional Info.

Falls

Date	Notes

Therapy History

Start Date	End Date	Type	Facility	Therapist	Additional Info.

Have you ever received any orthotic/prosthetic items such as braces, shoe inserts, splints, etc?

☐ Yes ☐ No When? _____

Why are you no longer using this device?

_____

Emergency Contact Information:
Relationship to Patient:_____ **Name:**_____

Street:_____ **City:**_____ **State:**_____ **Zip:**_____

Cell Phone Number:_____ **Home or Work (Circle One) Phone Number:**_____