TOTAL CARE
ORTHOTICS and PROSTHETICS

Medical History

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	☐ F ☐ M	**DOB:**	
Reason for visit today:	**Visit Date:**	**Tobacco Use and Type:**	
Device Received within the last five years Y / N	**If YES, when and ordering Dr:**	**Falls in last 6 Months:**	
Height: **Weight:**	**Referring Doctors:**	**Other Doctor:**	

☐ **Amputation?**
☐ **Your condition is a result of an accident from employment**
☐ **Your condition is a result of an Auto accident**
☐ **Your condition is a result of any other type of accident**

General Health: ☐ **Poor** ☐**Fair** ☐**Good** ☐ **Excellent**

Activity: ☐ **Low (K1)** ☐ **Medium (K2)** ☐ **Active (K3)** ☐ **Highly Active (K4)**

Do you have any of the following

☐ Heart Problems	☐ Hepatitis A or B	☐ Vision Problems	☐ Pacemaker/Defibrillator
☐ Hypertension	☐ Hepatitis C	☐ Parkinson 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	☐ Known Allergies (Including contact materials)	
☐ Osteoporosis	☐ Pulmonary Disease (TB)		

List all injuries related to your visit (sprains, fractures, falls, repetitive stress): When

Head:

Upper Extremity:

Spine:

Lower Extremity:

Surgeries:

Year:	**Reason:**	**Hospital:**

Current list of medications.

I attest that the information provided above is accurate to the best of my knowledge. I understand that providing incorrect information could result in my being responsible for the cost of services provided.

_____ _____

Signature **Todays Date**