Prosthetic Orthotic Center
Quality of Life is Our Concern

MEDICAL HISTORY FORM

PATIENT NAME:			TODAYS DATE:
DATE OF BIRTH:	SEX: MALE | FEMALE	HEIGHT:	WEIGHT:

Reason for today's visit?

Diagnosis | Affected side: Left | Right | Both

General Health: Poor | Fair | Good | Excellent

Are you currently under the care of a physician? Yes | No

If yes, providers name: | Date of last visit:

Referring physician:

There are limitations with some insurance coverage as to the frequency of providing certain services. Have you had the **same** or **similar item** prior to this? If so, **what did you get, when did you get it and where?** The details you provide us, will allow us to more accurately determine coverage and enable us to serve you better.

For the following questions, please check the appropriate boxes. Your answers are confidential and are for our records only. During the initial visit you may be asked some additional questions about your responses to this questionnaire.

Have there been any changes in your general health within the past year? ☐ YES ☐ NO

If yes, please explain:

Do you have or have you had any of the following?

☐ Diabetes: Date of last diabetic Exam / / Dr. who manages diabetes:

☐ Heart Problems	☐ Hepatitis A or B	☐ Vision Problems
☐ High Blood Pressure	☐ Hepatitis C	☐ Parkinson Disease
☐ Vascular Disease	☐ HIV Positive	☐ Alzheimer Disease
☐ Stroke	☐ Rheumatoid Arthritis	☐ Psychiatric Problems
☐ Seizure Disorder	☐ Obesity	☐ Alcoholism
☐ Kidney Disease	☐ Osteoarthritis	☐ Hearing Loss
☐ Osteoporosis	☐ Pulmonary Disease	☐ Pregnant
☐ Amputation (please specify) _____ _____	☐ Allergies (please specify) _____ _____	☐ Other (please specify) _____ _____

Do you use an assistive device to help you ambulate: None | Cane | Walker | Wheelchair

Currently taking any medications?

Is your condition a result of accident from: Employment | Auto Accident | Other Accident

If so, date of accident: | Type of accident:

PATIENTS SIGNATURE:	DATE:
PARENT/GUARDIAN SIGNATURE:	RELATIONSHIP: