Medical History Form

EXPRESS ORTHOTICS & PROSTHETICS

Height _____ ☐ Ft./In. ☐ Cms. Weight _____ ☐ Lbs. ☐ Kgs. ☐ With Device?

Shoe Size: _____ Are you diabetic? ☐ No ☐ Yes is yes: Type I ☐ II ☐ Insulin Dependent ☐

Do you use tobacco products?
☐ I have never used tobacco
☐ I currently use tobacco. If so, what type _____
☐ I used tobacco, but quit _____ years / months (circle one) ago
☐ I prefer not to answer

If your condition is the result of an accident or injury? ☐ No ☐ Yes **If yes, please complete below:**

Date of accident/injury / / Where it happened

_____ _____

Description of accident/injury: _____

Have you received any orthotics or prosthetic device(s) within the past five years? ☐ Yes ☐ No If yes, please list item(s) and date: _____

Do you have an amputation? Y / N If yes, [ ] Above Knee [ ] Below Knee [ ] Through Knee [ ] Through Ankle [ ] Partial Foot [ ] Above Elbow [ ] Below Elbow [ ] Other
_____

When did your amputation occur? _____ Month _____Year
(If unsure, please make your best guess)

In the past 6 months, have you lost your balance, slipped or tripped resulting in a fall? ☐ No ☐ Yes If yes, how many falls? ☐ 1 ☐ 2 ☐ 3+ times

Do you have any allergies? ☐ No ☐ Yes If yes, please list below:
Allergies: _____

Do you currently have, or have you previously had, any of the following medical conditions? Please check all that apply:

☐ Alzheimer's or Dementia	☐ Hepatitis A B C (circle type)	☐ Osteoarthritis
☐ Anxiety	☐ High Blood Pressure	☐ Osteoporosis
☐ Asthma	☐ HIV	☐ Parkinson's Disease
☐ Attention Problems, (ADHD)	☐ Infections	☐ Pulmonary Disease (TB)
☐ Brain Injury/ TBI	☐ Intestinal Problems	☐ Rheumatoid Arthritis
☐ Cancer	☐ Kidney Disease	☐ Seizure Disorders
☐ Depression	☐ Liver Disease	☐ Skin Problems
☐ Diabetes Type I	☐ Migraines	☐ Stomach Problems
☐ Diabetes Type II	☐ MRSA	☐ Stroke/TIA/CVA
☐ Hearing Loss	☐ Neurological Problems	☐ Vascular Disease
☐ Heart Problems	☐ Obesity	☐ Vision Problems

Details or others not listed: _____