



# Restore Orthotics and Prosthetics Medical History Form

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## MEDICAL HISTORY

Diagnosis: \_\_\_\_\_

Relevant Surgeries: \_\_\_\_\_

### MEDICAL CONDITIONS (CHECK ALL THAT APPLY):

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Hepatitis A, B or C    | <input type="checkbox"/> Vision Problems           | <input type="checkbox"/> Pacemaker/Defibrillator |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> Parkinson Disease         | <input type="checkbox"/> Seizure Disorder        |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Alzheimer Disease         | <input type="checkbox"/> Scoliosis/ Kyphosis     |
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> Spina Bifida              | <input type="checkbox"/> Currently Pregnant      |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Obesity                | <input type="checkbox"/> Clubfoot                  | <input type="checkbox"/> MRSA/ VRE               |
| <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Osteoarthritis         | <input type="checkbox"/> Muscular Dystrophy: _____ |  |
| <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Pulmonary Disease (TB) | <input type="checkbox"/> Other: _____              |  |

Medications: \_\_\_\_\_

## IDENTIFY ALL THAT IS TRUE TO HELP US IDENTIFY A PROPER TREATMENT PLAN:

### STRENGTH/ MOBILITY:

- Falls are never an issue
- Near-falls are an issue for me
- I currently use a prosthetic/ orthotic device
- I have used a prosthetic/ orthotic device in the past
- I currently use an assistive device (cane, Walker, crutches, etc.)
- Other: \_\_\_\_\_

### DIFFICULT WALKING CONDITIONS FOR ME INCLUDE:

- Uneven terrain
- Ascending/ descending Stairs
- Ascending or descending hill/ ramp
- Snow/ ice
- Other: \_\_\_\_\_

### WORK DETAILS:

- I am currently not working
- My job is \_\_\_\_\_
- My job requires use of stairs
- My job requires prolonged standing
- My job requires walking long distance or duration
- My job includes difficult walking conditions

### MY DAILY ACTIVITIES INCLUDE:

- Shopping
- Preparing meals
- Cleaning my home
- Performing yardwork
- Walking the dog

### LIVING SITUATION:

- I live alone
- I live with \_\_\_\_\_
- I care for children at home
- I must use stairs at home
- There are difficult walking conditions around my home

### MY HOBBIES/OTHER ACTIVITIES INCLUDE:

- Long walks
- Hiking
- Running
- Gardening
- Other: \_\_\_\_\_

OTHER PERTINENT INFORMATION: \_\_\_\_\_

Signature

Print Name

Relationship to Patient