PATIENT MEDICAL HISTORY

PATIENT NAME　DATE OF BIRTH　AGE　HT　WT　DATE

HAVE YOU RECENTLY RECEIVED A CUSTOM DEVICE? YES ☐ NO ☐

HAVE YOU BEEN TO OUR OFFICE BEFORE? YES ☐ NO ☐

MALE ☐ FEMALE ☐

PATIENT HAS RECENTLY LOST/GAINED WT? YES ☐ NO ☐

AMPUTATION DATE (IF AMPUTEE)

REASON FOR VISIT

RELEVANT DIAGNOSES

REFERRING PHYSICIAN

PREFERRED HOSPITAL

DO YOU SUFFER FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Check all that apply to you)

HEART DISEASE	☐	**PERIPHERAL VASCULAR DISEASE**	☐	**DIABETES**	☐	**CVA**	☐
FOOT DROP	☐	**NEUROPATHY** ☐ **ARTHRITIS**	☐	**LEG LENGTH DISCREPANCY**			☐
OBESITY	☐	**PARTIAL FOOT AMPUTATION**	☐	**HISTORY OF CALLUSES OR ULCERS**			☐

PLEASE NOTE ANY OTHER COMPLICATIONS BELOW

PLEASE LIST ANY PRIOR SURGERIES BELOW

DEVICE HISTORY

PRESENT DEVICE

DATE RECEIVED　PRACTITIONER/FACILITY

RESULTS-LIKES/DISLIKES:

PAST DEVICES

DATE RECEIVED　DEVICE

DATE RECEIVED　DEVICE

PRESENT DEVICE-PRECONDITION ACTIVITY LEVELS

OCCUPATION/EMPLOYMENT　AVOCATION/WHAT DO YOU DO RECREATIONALLY?

WHAT ARE YOUR OBJECTIVES AND GOALS?