

# MEDICAL HISTORY

## **PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

## **ACCIDENT INFORMATION**

Is your condition a result of an accident? Yes/ No (skip this section if No)

Type of accident (please circle): Auto Employment Other

Please Explain:

\_\_\_\_\_

Date of Accident: \_\_\_\_\_

## **SAME/SIMILAR DEVICE(S)**

Have you ever been fit with a same or similar appliance as what you are here for today? Yes/No

If yes, please explain: \_\_\_\_\_

Approximate date of when you were fit with a same/similar device: \_\_\_\_\_

## **HEALTH CONDITIONS**

General Health: Poor/Fair/Good/Excellent

Please mark any of the following conditions that pertain to you.

\_\_\_\_\_ Heart Problems

\_\_\_\_\_ Osteoarthritis

\_\_\_\_\_ Hypertension

\_\_\_\_\_ Pulmonary Disease (TB)

\_\_\_\_\_ Vascular Disease

\_\_\_\_\_ Vision Problems

\_\_\_\_\_ Stroke

\_\_\_\_\_ Parkinson Disease

\_\_\_\_\_ Diabetes

\_\_\_\_\_ Alzheimer Disease

\_\_\_\_\_ Kidney Disease

\_\_\_\_\_ Psychiatric Problems

\_\_\_\_\_ Hepatitis A or B

\_\_\_\_\_ MRSA or Staph

\_\_\_\_\_ HIV Positive

\_\_\_\_\_ Allergies to Contact Materials

\_\_\_\_\_ Rheumatoid Arthritis

\_\_\_\_\_ Polio

\_\_\_\_\_ Obesity

\_\_\_\_\_ C diff

List any other conditions that you feel might affect your treatment: \_\_\_\_\_

\_\_\_\_\_

NOTICE OF CONFIDENTIALITY: This document contains unconditionally private medical records. Any improper use of the information contained herein constitutes a breach of patient medical confidentiality.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_