# REAL LIFE PROSTHETICS™

## Patient History Form

*To be completed by Patient/Responsible Party*

**Patient Name:** _____ **Date:** _____

**Date of Birth:** _____ **Height:** _____ **Weight:** _____ **Shoe Size:** _____

**Assisted Device:** (*check all that apply*)

- ☐ Crutches
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Motorized Wheelchair or Scooter

**Employment:**

- ☐ Employed
  *Job Title:* _____
- ☐ Disability
- ☐ Unemployed/Previously Employed
  *Job Title:* _____

**Home Set-up:** _____ *Story Home* _____ *Stairs to Enter Home* _____ *Stairs to Bedroom*

**Do you use Tobacco?** ☐ Yes ☐ No

**Rehabilitation Training PT/OT?** ☐ Yes ☐ No

***If "YES" Where:*** _____

***PT/OT Name:*** _____

***Phone Number:*** _____

**Medical History:**

- ☐ Diabetes
- ☐ Stroke (CVA)
- ☐ Peripheral Vascular Disease
- ☐ Visual Impairment
- ☐ Cardiovascular Disease
- ☐ Other
- ☐ Urinary Incontinence
- ☐ Depression
- ☐ Arthritis/Osteoarthritis
- ☐ MRSA
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ Allergies *(list below)*

_____

_____

*Any other medical condition you may think would make orthotic/prosthetic fit or function more complex, please specify:*

_____

_____

_____

**Past Surgical History:** *(date and procedure)*

_____

_____

_____

**Activities Prior to Injury/Amputation:**

_____

_____

_____

**Short Term/Long Term Goals:**

_____

_____

_____

_____ _____

*Patient/Responsible Party Signature* *Date*