REAL LIFE PROSTHETICS™

To be completed by Patient/Responsible Party

Patient Name: _____ **Date:** _____

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

Assistive Device (check all 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
- ☐ Urinary Incontinence
- ☐ Depression
- ☐ Arthritis/Osteoarthritis
- ☐ MRSA
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ Allergies (list Below)

_____

_____

- ☐ Other

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*