Gulf Coast Orthotics & Prosthetics Center, LLC

Medical History Form

Patient Name _____ DOB _____

Current Weight _____ Height_____

Do you have a history of the following, please circle:

Allergies to materials	Yes	No	Heart Trouble	Yes	No
If Yes, what _____			Lung Disease	Yes	No
Chest Pain	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Convulsive Disorder	Yes	No
Stroke	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Headaches	Yes	No	Positive HIV Testing	Yes	No
Dizziness	Yes	No	Exposure to HIV	Yes	No
Tinnitus (ringing in ear)	Yes	No	Anemia	Yes	No
Hearing Loss	Yes	No	Asthma	Yes	No
Difficulty Breathing	Yes	No	Glaucoma	Yes	No
Vision Problems	Yes	No	Lack of Peripheral Vision	Yes	No

Please list all of the medications you are taking and the dosage you take (including over-the-counter) _____
_____
_____

Do you drink alcohol? Yes No How Often? _____

Do you use tobacco products? Yes No # pack(s)/chew per day_____

Have you ever received a prosthesis or orthosis? Yes No

Age of current device ____ Unknown___1-2 Yr.___ 2-5Yr.___ 5-10 Yr. ___ 10+Yr.___
Please indicate what side your device is: ____Right ____Left ____Bilateral

Type of home (circle one): 1 Level 2 Levels 3 Levels Approx. how many stairs?___

Family Support: ___Yes ___No Psychiatric care: ___Yes ___No
Physical Therapy: ___Yes ___No
Activities/Goals: _____

I affirm the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and is my responsibility to inform this office of any changes in my medical status.

_____
Signature Date