Medical History

Orthotics/Pedorthics

Name: Last __________________ First ___________________ MI _________ **Date of Birth** ___/___/____ **Age**:_____

Height:_____ Weight:________
Recent Weight Changes: Y ? N
If yes, explain: ______________
____

Referring Physician:___________________ Phone:_____________________
Physical Therapist:____________________ Phone:_____________________
Occupational Therapist:________________ Phone:_____________________
Surgeon:______________________________ Phone:_____________________

Is this Injury Related? Y / N
If yes, injury level (s) & side (s)
____
Cause of Injury?______________
____

Previous or scheduled surgeries? Y / N
If yes, first date: ___/___/___
Second date: ____/____/___
Type of Surgery? ______________________
____

Did you need assistive devices before injury or surgery? Y / N

Activities of Daily Living (ADL's)

Do you have an orthotic device? Y / N If yes, what type?____________
When/Where was it made? __/__/__ ____________________________
Device meet functional needs? Y / N ____________________________
Are you experiencing pain or discompfort with current device? Y / N If yes, what type of device? ____________________________

Do you want an Orthosis? Y / N
For Transfers? Y / N
For Walking? Y / N
For Pain Reduction? Y / N
For Support? Y / N

Living Status: Live Alone / Live with Assistance
Living Conditions: Level Surfaces / Level Surfaces with Stairs / Uneven Surfaces Uneven Surfaces with Stairs
Work Conditions: Level Surfaces / Level Surfaces with Stairs / Uneven Surfaces Uneven Surfaces with Stairs
Activities Pre-injury/Surgery: Bicycling / Jogging / Long Walks / Gardening / Shopping / Other:__________________
Activities Post-injury/Surgery: Bicycling / Jogging / Long Walks / Gardening / Shopping / Other:__________________

Are you experiencing difficulty walking? Y / N Explain:___________________
Are you experiencing difficulty with daily living? Y / N Explain:___________________
What assistive equipment do you have at home? Ramp / Lift Chair / Bedside Toilet / Other:_______________________
What assistive equipment do you use for mobility? None / Cane / Walker / Electric Scooter/Wheel Chair / Wheel Chair

Health Conditions *(mark all that apply)*

___ Heart Problems ___ Diabetes ___ Hepatitis A,B,C ___ Kidney Disease
___ Hypertension ___ Currently Pregnant ___ HIV Positive ___ Vision Problems
___ Vascular Disease ___ Pulmonary Disease (TB) ___ Rheumatoid Arthritis ___ Osteoarthritis/Osteoporosis
___ Stroke ___ Charco Disease ___ Obesity ___ Parkinson Disease
___ Seizure Disorder ___ MRSA ___ Psychiatric Disorders ___ Other:_________________
___ **Allergies** (latex/ polypropylene / plastic / silicone / etc.):____

How did you hear about Orthocare Solutions?

☐ Physician/Office ☐ Therapist ☐ Friend/ Neighbor ☐ Insurance Company ☐ Case Worker

From time to time Orthocare solutions sends out an email to our patients with important health information. If you'd like to receive such information via email, please provide your email address here:_______________________________________ Please Initial:______________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Orthocare Solutions. I understand that I am financially responsible for any balance. I also authorize Orthocare Solutions or my insurance company to release any information required to process my claims.

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Patient/Guardian signature **Printed Name** **Relationship to Patient** **Date**