Medical History Form

Patient Name:

Today's Date:

Height: Weight **Reason For Amputation:**

MEDICAL HISTORY

Diagnosis: _____

Relevant Surgeries: _____

MEDICAL CONDITIONS (CHECK ALL THAT APPLY):

- ☐ Heart Problems
- ☐ Hypertension
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Hepatitis A, B or C
- ☐ Cerebral Palsy
- ☐ HIV Positive
- ☐ Rheumatoid Arthritis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pulmonary Disease (TB)
- ☐ Vision Problems
- ☐ Parkinson Disease
- ☐ Alzheimer Disease
- ☐ Spina Bifida
- ☐ Clubfoot
- ☐ Muscular Dystrophy: _____
- ☐ Other: _____
- ☐ Pacemaker/Defibrillator
- ☐ Seizure Disorder
- ☐ Scoliosis/ Kyphosis
- ☐ Currently Pregnant
- ☐ MRSA/ VRE

Medications: _____

IDENTIFY ALL THAT IS TRUE TO HELP US IDENTIFY A PROPER TREATMENT PLAN:

STRENGTH/ MOBILIBTY:

- ☐ Falls are never an issue
- ☐ Near-falls are an issue for me
- ☐ I currently use a prosthetic/ orthotic device
- ☐ I have used a prosthetic/ orthotic device in the past
- ☐ I currently use an assistive device (cane, Walker, crutches, etc.)
- ☐ Other: _____

WORK DETAILS:

- ☐ I am currently not working
- ☐ My job is _____
- ☐ My job requires use of stairs
- ☐ My job requires prolonged standing
- ☐ My job requires walking long distance or duration
- ☐ My job includes difficult walking conditions

LIVING SITUATION:

- ☐ I live alone
- ☐ I live with _____
- ☐ I care for children at home
- ☐ I must use stairs at home
- ☐ There are difficult walking conditions around my home

DIFFICULT WALKING CONDITIONS FOR ME INCLUDE:

- ☐ Uneven terrain
- ☐ Ascending/ descending Stairs
- ☐ Ascending or descending hill/ ramp
- ☐ Snow/ ice
- ☐ Other: _____

MY DAILY ACTIVIES INCLUDE:

- ☐ Shopping
- ☐ Preparing meals
- ☐ Cleaning my home
- ☐ Performing yardwork
- ☐ Walking the dog

MY HOBBIES/OTHER ACTIVITIES INCLUDE:

- ☐ Long walks
- ☐ Hiking
- ☐ Running
- ☐ Gardening
- ☐ Other: _____

OTHER PERTINENT INFORMATION: _____

_____

_____

Signature Print Name Relationship to Patient

Medical History Form

PHYSICIAL THERAPY INFORMATION

Yes ☐ No ☐ Are you currently or have you recently worked with a physical and/or occupational therapist?

If yes, please answer the following: **Physical Therapist** ☐ **Occupational Therapist** ☐

Name of Therapist: _____ **How often?** _____

ADDITIONAL INFORMATION

Yes ☐ No ☐ Have you received a like or similar device within the last 5 years from either Nutech Institute LLC or any other provider?

Yes ☐ No ☐ Are you currently residing in a nursing home, assisted living or group home?

If yes, Name of Facility: _____

Phone Number: _____

Yes ☐ No ☐ Have you received a motorized wheelchair within the last 5 years?