POWELL
spirit. support. science

Medical History
PROSTHETIC

Name:	**Date of Birth:**
Height: **Weight:**	**Recent Weight Change:**
Profession:	**Physical Therapist:** *Location:*
Date of amputation:	**Occupational Therapist:** *Location:*
Amputation level (s) & Side(s):	**Cause of amputation:**
Surgeon: *Location:*	**Referring Physician:** *Location:*
Medications:	

Check all that apply:

❑ Heart disease	❑ Obesity	❑Cancer _____
❑Pacemaker/Defibrillator	❑MRSA	❑ Allergy_____
❑Diabetes	❑Cellulitis	❑ Polio
❑Vascular disease	❑Vision Problems	❑Charcot Disease
❑Pulmonary Disease (TB)	❑Blind	❑Seizures
❑Claudication	❑Hearing Loss	❑RSD
❑ Stroke	❑Parkinson Disease	❑HIV
❑High Blood Pressure	❑Alzheimer Disease	❑Osteoporosis
❑Kidney Disease	❑Psychiatric Problems	❑Neuropathy
❑Hepatitis	❑Alcoholism	❑MS _____
❑Rheumatoid Arthritis	❑Smoker	❑ CP_____
❑Osteoarthritis	❑Currently pregnant	❑Other_____

❖Do you have a prosthesis? Yes / No

❖When was it made? _____

❖Where was it made? _____

❖Does your prosthesis meet your functional needs? Yes / No

❖What Problems are you having with current device? _____

❖Are you experiencing any pain or discomfort with your current prosthesis? Yes / No

*Describe*_____

Activities of Daily Living (ADL's) - Prosthetic

Circle all that apply:

Do you have a desire to ambulate with a prosthesis? Yes or No

For Transfers? Yes or No **For Walking?** Yes or No

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-amputation: Bicycling Jogging Long Walks Gardening Shopping Fishing

*Other*_____

Activities Post amputation: Bicycling Jogging Long Walks Gardening Shopping Fishing

*Other*_____

Are you experiencing difficulty walking? Yes or No

- *Describe*_____

Are you experiencing difficulties with activities of daily living? (bathing, dressing, toileting, etc.) Yes or No

- *Describe*_____

What medical equipment do you have at home? Ramp Lift chair Bedside toilet Other_____

What assistive devices do you use in household for mobility? No assistive device needed Cane(s) Walker Electric scooter Wheelchair Electric wheelchair Other_____

What assistive devices do you use in community for mobility? No assistive device needed Cane(s) Walker Electric scooter Wheelchair Electric wheelchair Other_____

Did you need assistive devices before limb(s) were amputated? Yes or No

- *Describe*_____

Fill in Blanks:

Normal Daily Activity: Seated _____% Standing _____% Walking _____%

Activities you are unable to do:

- *Describe*_____

Check one that applies:

How did you hear about Powell O & P?

☐ MD / MD office staff ☐ Therapist ☐ Friend / Neighbor ☐ Insurance Company ☐ Case Worker

Initial in space provided:

___From time to time Powell O&P sends out an email to our patients with important health news from our industry. If you'd like to receive our e-newsletter, please provide your email address here:_____

All information is accurate to my knowledge:

Signature: _____

Printed Name: _____ Date: _____