POWELL spirit. support. science.	Medical History Prosthetic Form

Name:				Date of Birth:	
Height:		Weight:		Recent Weight Change:	
Profession:					
Medication(s):					

Date of Amputation:		Cause of Amputation:	
Amputation level(s) & Side(s):			
Surgeon:		Location:	
Referring Physician:		Location:	
Physical Therapist:		Location:	
Occupational Therapist:		Location:	

Please check ALL that apply.

☐	Alcoholism	☐	HIV (Aids)	☐	Psychiatric Problems
☐	Alzheimer Disease	☐	Kidney Disease	☐	Pulmonary Disease (TB)
☐	Blind	☐	MRSA	☐	Rheumatoid Arthritis
☐	Cardiac/Heart Disease	☐	Neuropathy	☐	RSD
☐	Cellulitis	☐	Obesity	☐	Seizures
☐	Charcot Disease	☐	Osteoarthritis	☐	Smoker
☐	Claudication	☐	Osteoporosis	☐	Stroke
☐	Diabetes	☐	Pacemaker/Defibrillator	☐	Vascular Disease
☐	Hearing Loss	☐	Parkinson Disease	☐	Vision Problems
☐	Hepatitis	☐	Polio		
☐	High Blood Pressure	☐	Pregnancy (CURRENTLY)		

If yes to allergy, cancer, etc. below, please expand with additional information to the right.		
☐	Allergy	
☐	Cancer	
☐	CP	
☐	MS	
☐	Other	

Do you have a prosthesis?	Select one	When was it made?	
Where was it made?			
Does your Prosthesis meet your functional needs?	Select one		
What problems are you having with current device?			
Are you experiencing any pain or discomfort with your current prosthesis?	Select one		
Describe:			

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Activities of Daily Living (ADL's) – Prosthetic

Do you have a desire to ambulate with a prosthetic?	Select one
For transfers?	Select one
For walking?	Select one
Living Status	
Living Conditions	
Work Conditions	

Activities Pre-amputation (check all that apply)?

☐	Bicycling	☐	Jogging	☐	Long Walks	☐	Gardening	☐	Shopping	☐	Fishing
Other											

Activities Post-amputation (check all that apply)?

☐	Bicycling	☐	Jogging	☐	Long Walks	☐	Gardening	☐	Shopping	☐	Fishing
Other											

Are you experiencing difficulty with walking?	Select one
Describe	

Are you experiencing difficulties with activities of daily living? (bathing, dressing, toileting, etc.)	Select one
Describe	

What medical equipment do you have at home (check all that apply)??

☐	Ramp	☐	Lift Chair	☐	Bedside Toilet
Other					

What assistive devices do you use in household for mobility (check all that apply)?

☐	No assistive device needed	☐	Walker	☐	Wheelchair
☐	Cane(s)	☐	Electric Scooter	☐	Electric Wheelchair
☐	Other				

What assistive devices do you use in community for mobility (check all that apply)?

☐	No assistive device needed	☐	Walker	☐	Wheelchair
☐	Cane(s)	☐	Electric Scooter	☐	Electric Wheelchair
☐	Other				
Did you need assistance devices before limb(s) were amputated?			Select one		
Describe					

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Normal Daily Activity (please fill in the blanks with percentage – should sum to 100%).

Seated		%	Standing		%	Walking		%
Activities you are unable to do:								
Describe each activity:								

How did you hear about Powell O & P (check all that apply)?

☐	MD/MD Office Staff	☐	Therapist	☐	Friend/Neighbor	☐	Insurance Co.	☐	Case Worker

From time-to-time Powell O & P sends out an email to our patients with important health news from our industry.

Would you like to be added to the email list?	Select one
If yes, what e-mail should be added to the list?	

All Information is accurate to my knowledge:

Printed Name		Date	
Signature			