AlliedOP

MEDICAL HISTORY & FINDINGS

Date_____ Office_____

PATIENT INFORMATION

Name_____
Last Name First Name Initial

Sex ☐ M ☐ F Age_____ DOB_____ HT_____ WT_____

Referring MD_____

CLINICAL

Diagnosis:_____ RT LT Bilateral

Chief Complaint: Date of Onset:

Patient's Physical Condition	**Comments**
Is the Patient's Weight stable? Yes____ No____	
Current Activities (sports,…)	
Work Activities	
Muscle weakness Yes____ No____	
Has the patient been treated for the same problem before? Yes____ No____	
If Yes, explain:	

MEDICATIONS

Current Meds that will affect treatment:

Medications that cause water retention or weight fluctuation:

Are you allergic to Latex, Neoprene, or any types of glues products? Yes____ No____

PAST MEDICAL HISTORY

	Yes	No		Yes	No
High Blood Pressure			Diabetes		
Kidney Disease			Heart Problems		
Stroke			Blood Clots		
Cancer			Vascular Problems		

OTHER:

RELATED INFORMATION

Current Orthotic/ Prosthetic User: Yes____ No____ Type of Orthosis/ Prosthesis:

Does current device need	repair Yes___ No___		replacement Yes___ No___	Adjustment Yes___ No___	
Current Amputee? Yes____ No____		Amputation Level			

Any Medical conditions or treatments that may affect your care?

What is your goal with the use of the device prescribed?

_____ _____

Clinician Signature Date