PERRY PROSTHETICS

PATIENT INFORMATION:

NAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

(H) PHONE: _____-_____-_____ (W) PHONE: _____-_____-_____ (C) PHONE: _____-_____-_____

EMAIL ADDRESS: _____ PREFERED METHOD OF CONTACT_____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

GENDER: M / F MARITAL STATUS: M S W D SPOUSE'S NAME:_____

EMPLOYER:_____

ADDRESS:_____ PHONE:_____-_____-_____

EMERGENCY CONTACT:_____ PHONE:_____-_____-_____

RELATIONSHIP TO PATIENT: _____WORK PHONE:_____-_____-_____

EMERGENCY CONTACT ADDRESS: _____

IF MINOR:

PARENT OR GUARDIAN:_____ PHONE:_____-_____-_____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

NAME OF INSURED: _____ NAME OF INSURED:_____

INSURED'S DATE OF BIRTH: _____ INSURED'S DATE OF BIRTH:_____

GROUP #: _____ GROUP #:_____

ID/POLICY #: _____ ID/POLICY #:_____

MEDICAL INFORMATION:

PRIMARY CARE PHYSICIAN:_____ PHONE:_____-_____-_____

CITY/STATE: _____ DATE OF LAST APPT.:_____

AMPUTATING SURGEON:_____ PHONE:_____-_____-_____

CITY/STATE: _____ DATE OF LAST APPT.:_____

DATE OF AMPUTATION: _____ AMPUTATION LEVEL: _____
(BELOW KNEE, ABOVE KNEE, ETC.)

CAUSE OF AMPUTATION: _____

CURRENT: HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____PANT INSEAM:_____

Patient Initials:_____

PERRY PROSTHETICS

PLEASE BE ADVISED: WITHHOLDING OR FALSIFYING MEDICAL INFORMATION MAY BE DETRIMENTAL TO YOUR PROSTHETIC CARE AND REHABILITATION.

Recently Experienced:

☐ Unexplained Weight Change ☐ Weakness ☐ Numbness/Tingling ☐ Pain

☐ Fever/Chills/Sweats ☐ Fatigue ☐ Nausea/Vomiting ☐ Mood Swings

Currently Under the Care of:

☐ Medical Doctor MD ☐ Psychiatrist/Psychologist ☐ Chiropractor ☐ Dentist

☐ Osteopath DO ☐ Physical Therapist ☐ Massage Therapist ☐ Other _____

What treatment in the last three months by this/these provider(s):_____

_____

_____

_____

_____

Other Surgeries:

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Over the Counter Medications:

☐ Asprin ☐ Antihistamines ☐ Decongestants ☐ Caffeine Stimulants

☐ Acetamenophen ☐ Antacid ☐ Vitamins/Minerals ☐ Others

☐ Ibuprofen ☐ Homeopathic Remedies ☐ Laxatives _____

Please provide a list of currently prescribed medications.

Allergies to medications: _____

Allergies to: Latex: Y / N Wool: Y / N Powders: Y / N Lotions: Y / N Other: Y / N _____

Smoke Cigarettes or Chewing tobacco: Y / N _____ pack/day Drink Alcohol: Y / N _____ drinks/ day week month

Have you ever been treated for substance abuse/addiction? Y / N When:_____ Status/Outcome:_____

_____

Have you ever been treated for mental condition(s)?: Y / N When:_____ Status/Outcome:_____

_____

History of:

☐ Diabetes Type ____I ____ II ☐ Heart Disease ☐ Hypertension ☐ Allergies

☐ Stroke ☐ Respiratory Distress ☐ Dizziness ☐ Cancer

☐ Anemia ☐ HIV ☐ Hepatitis ☐ Thyroid problems

☐ Rheumatoid arthritis ☐ Other arthritic problems ☐ Multiple Sclerosis ☐ Epilepsy

If yes to Diabetes: Treating Physician(s):_____

Dialysis? Y /N If yes, treatments are on: ___Mon ___Tue ___Wed ___Thur ___Fri ___Sat ___Sun

If Stroke or Heart treatment: When_____ Treating Physician(s):_____

Do you have a DNR or Living Will? Y / N Provide a copy for our records? Y / N

Patient Initials:_____

PERSONAL GOALS

LIST TYPES OF ACTIVITES PRIOR TO AMPUTATION:

_____ _____ _____

_____ _____ _____

MY GOALS FOR THIS YEAR:

_____

_____

MY GOALS FOR THREE YEARS:

_____

_____

LIST ANY ACTIVITIES THAT YOU ARE SPECIFICALLY CONCERNED ABOUT DOING:

_____ _____ _____

_____ _____ _____

DO YOU HAVE ANY SPECIFIC QUESTIONS IN REGARDS TO PROSTHETICS OR THE REHABILITATION PROCESS?

_____

_____

_____

I hereby certify that the information provided in this document is correct to the best of my knowledge, and understand that any falsification of information may impede my current or continuing prosthetic care.

Patient/Guardian Signature_____ Date_____