MILLER
PROSTHETICS & ORTHOTICS

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Medical History

Name_____ Date_____

Height _____ Weight _____ Recent change? Y N How much?_____

Why are you here today? _____

Diagnosis _____ Affected side L R Both

General Health: Poor Fair Good Excellent

There are limitations with some insurance coverage as to the frequency of providing certain services. Have you had the same or similar service prior to this? If so, what did you get, when did you get it and where? The details you provide us, will allow us to more accurately determine coverage and enable us to serve you better.

_____

_____

Have you had or do you have any of the following (please circle)

heart problems	hepatitis a or b	vision problems	pacemaker/defibrillator
hypertension	hepatitis c	Parkinson disease	seizure disorders
vascular disease	HIV positive	Alzheimer disease	hearing loss
stroke	rheumatoid arthritis	psychiatric problems	currently pregnant
diabetes	obesity	alcoholism	MRSA
kidney disease	osteoarthritis	known allergies (including contact materials)	
osteoporosis	pulmonary disease (TB)		

Allergies_____

List any other conditions you feel might affect your treatment including dates and descriptions of surgeries_____

Currently taking any medications?_____

Is your condition a result of accident from: Employment Auto Accident Other Accident

Date of Accident:_____

State Accident Occurred:_____

Type of Accident:_____