SYRACUSE PROSTHETIC ORTHOTIC CENTER

WHERE TRADITION AND TECHNOLOGY TRANSFORM LIVES

Patient Medical Profile

Today's Date _____ Patient Name_____ DOB: _____

Tobacco Use: ☐Yes ☐No Type Used: _____ How much per day: _____

Number of Falls in last 6 months _____ Number of Hospital, ER, Urgent Care Visits in last 6 months _____

General Health: ☐Excellent ☐Good ☐Fair ☐Poor Health Problems:_____

Patient Reported Activity Level: ☐Very Active ☐Active ☐Limited Activity ☐Sedentary

Cause: ☐Accident from Employment ☐Auto Accident ☐Other Accident ☐Condition Since Birth

Description:_____

Received Device within the Past Five Years: ☐Yes ☐No Device Details _____

Allergies: ☐Yes ☐No Type: _____

Current Medications: ☐Yes ☐No _____

Past Surgeries: ☐Yes ☐No _____Date:_____

Amputations: ☐Yes ☐No Level:_____ Reason:_____ Date:_____

Other Medical Conditions

☐Alzheimer's or Dementia	☐High Blood Pressure	☐Osteoporosis	☐Anxiety
☐HIV	☐Parkinson's Disease	☐Asthma	☐Infections
☐Pulmonary Disease(TB)	☐Brain Injury/TBI	☐Intestinal Problems	☐Cancer
☐Rheumatoid Arthritis	☐Kidney Disease	☐Seizure Disorders	☐Depression
☐Liver Disease	☐Skin Problems	☐Diabetes Type I	☐Diabetes Type II
☐Migraines	☐Stomach Problems	☐Hearing Loss	☐MRSA
☐Stroke/TIA/CVA	☐Neurological Problems	☐Vascular Disease	☐Obesity
☐Heart Problems	☐Vision Problems	☐Osteoarthritis	☐Other Condition(s)

Other Condition(s) _____

Questions? Call Toll Free 855-476-9697 or visit us online at www.SyracuseProstheticCenter.com
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