Medical History Worksheet

Date _____

Demographics

Name _____ *DOB* _____ *Height* _____ *Weight* _____

Hand dominance _____

Limb loss and difference related history

Date of surgery _____ *Reason for surgery* _____

Residual limb status _____

- *Skin Condition* _____
- *Pain* _____
- *Phantom pain* _____
- *Contracture* _____
- *Use of ACE wraps, shrinker sock or limb protector* _____

Rehabilitation Dates _____ *Assistive devices using* _____

Current Providers

Medical Team Members	Name	Phone
Surgeon		
Physical Therapy		
Occupational Therapy		
Primary Care Physician (PCP)		
Case Manager		
Psychologist/Psychiatrist		
Physical Medicine & Rehab		
Prosthetist		
Other		

Medical History Worksheet

Medications (Prescription)

Brand name	Generic Name	Dosage

Preferred Pharmacy *Phone:*

Over The Counter: such as Advil, Aleve, Asprin, BC powder, vitamins, supplements, etc.

Medications (OTC)

Brand name	Used for	How taken

Medication and other Allergies

(such as penicillin, sulfa, codeine, aspirin, NSAIDS, iodine, tape, latex, gelatin, contrast dye etc.)

Surgical History (Please check all applicable)

☐ Tonsillectomy	☐ Carpal Tunnel	☐ Pacemaker	☐ C-Section	☐ Amputation
☐ Appendectomy	☐ Cataracts	☐ Back Surgery	☐ Mastectomy	☐ Other Limb Surgeries
☐ Hysterectomy	☐ Hip Replacement	☐ Heart Surgery	☐ Lasik	☐ Other:
☐ Gallbladder	☐ Knee Replacement	☐ Hernia Repair	☐ Peripheral Vascular	
☐ Thyroid	☐ Gastric Bypass	☐ Fracture Surgery	☐ Cosmetic	

Medical History Worksheet

Medical History (Please check all applicable)

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Bowel Disease
- ☐ Brain Aneurysms
- ☐ Brain Tumor
- ☐ Cancer
  Type _____
- ☐ Colitis
- ☐ Congestive Heart failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Erythematosus
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ IBS
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile RA
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Meningitis
- ☐ Mental Illness
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Muscle Disease
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peripheral Vascular Disease
- ☐ Pituitary Tumor/Disease
- ☐ Post-Menopausal
- ☐ Prostate Disease
- ☐ Pulmonary Embolism
- ☐ Reaction to Anesthesia
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Scoliosis
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Spine Tumors
- ☐ Spondyloarthropathy
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Systemic Lupus
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ Visual Impairment
- ☐ Other:

Family History (Immediate family history, living, deceased, age at death, etc.)

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed*

Gender Identification: _____

No. of Children _____

Partner's name: _____ *Age* *Occupation* _____

His/her medical condition: _____

Who lives with you? _____ *Legal Guardianship/Power of Attorney:* _____

Who comprises your support network? _____

What responsibilities will they take as caregivers? _____

Parents Living: ☐ *Live Nearby* ☐ *Able To Assist* ☐ *Siblings* ☐ *Living Elsewhere* ☐ *Extended Family*

Available support systems? _____

Family History (continued)

Would you consider your home life: ☐ *Struggling* ☐ *Strained* ☐ *Fair* ☐ *Good* ☐ *Excellent*

Who performs upkeep indoors? _____ *Outdoors?* _____

Any immediate repair/maintenance needs? _____

Transportation: _____ *Valid driver's license?* _____ *Type of vehicle(s)* _____

Who lives with you? _____ *Legal Guardianship/Power of Attorney:* _____

Automatic or Manual Transmission? _____ *Current Ability to Drive* _____

Tobacco use: ☐ *No* ☐ *Yes* ☐ *Formerly* *Type:* ☐ *Cigarettes* ☐ *Snuff* ☐ *Chew* ☐ *Cigar* ☐ *Vape* ☐ *E-Cigarette*

# of Years _____ *Year Quit?* _____

Ever tried to quit? ☐ *No* ☐ *Yes*

Illegal/Illicit Drug Use/Abuse: (confidential) ☐ *No* ☐ *Yes*

Drug of choice: _____

Alcohol use: ☐ *No* ☐ *Yes* ☐ *Formerly*

Amount _____ *Year Quit* _____ *# of Years* _____ *Type* _____ *Frequency* _____

Caffeine use: ☐ *No* ☐ *Yes* ☐ *Formerly*

Type _____ *Amount* _____

Please Circle Any of Your Pre-Amputation Interests (hobbies/clubs/organizations/ church/recreation)

☐ hunting	☐ antiques	☐ golf	☐ other(s):
☐ fishing	☐ reading	☐ gardening	_____
☐ church	☐ television	☐ winter activities	_____
☐ crafts	☐ athletic pursuits	☐ water activities	

What would you consider your pre-amputation activity level to be:

☐ *Sedentary* ☐ *Light* ☐ *Medium* ☐ *Active* ☐ *Athletic*

What are your post amputation activity goals? _____

Medical History Worksheet

Education

Highest grade completed: ☐ *GED* ☐ *High School Diploma* ☐ *Attend College* ☐ *College or Advanced Degree*

☐ *Vocational School* ☐ *Specialized Training* ☐ *Certification* ☐ *Military Service /Job*

☐ *Rank at Departure*

Vocation

Current line of work/job title:

Do you like your job: ☐ *No* ☐ *Yes*

Length of time at the company: *Length of time in this role:*

Physical requirements of your job/attach job description if available.

Has your work status changed as a result of your present illness/injury: ☐ *No* ☐ *Yes*

If yes, what is your current work status: ☐ *Unemployed* ☐ *Light duty* ☐ *Unable to work*

Previous Employer, length of employment.

Include Legal Guardianship/Power of Attorney/Advanced Directives in your medical binder