|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT’S FIRST NAME** | **MI** | **LAST NAME** | **GENDER** |
|  |  |  | **m MALE FEMALE** |
| **CURRENT WEIGHT** | **HEIGHT** |  |  |
|  |  |  |  |

Atlantic Prosthetic Services

**PATIENT QUESTIONNAIRE FORM**

1. Do you have a Primary Physician? YES NO

 What is their Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have an Orthopedic Surgeon? YES NO

 What is their Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a Podiatrist? YES NO

 What is their Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a Physical Therapist? YES NO

 What is their Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you having problems with any of the following areas? *Please check of all that apply*

 Neck Back Knee Ankle Foot Arm Wrist Finger Hip Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If you have checked any of the boxes above, please tell us how long have you had these problems?

 \_\_\_\_\_\_\_\_\_ days \_\_\_\_\_\_\_\_\_\_\_\_ weeks \_\_\_\_\_\_\_\_\_\_\_ months \_\_\_\_\_\_\_\_\_\_\_years

1. Do you have a problem walking? YES NO

 If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a problem bending? YES NO

 If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have problems standing? YES NO

 If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you Weakness of the Leg(s)? YES NO / If yes, which side? Right Left Both
2. Do you have Weakness of the Ankle? YES NO / If yes, which side? Right Left Both
3. Are you a Diabetic? YES NO If yes, are you Insulin Dependent Non Insulin
4. Have you ever worn Diabetic Shoes? YES NO
5. Have you ever worn Prosthesis? YES NO When did you get your last device: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If yes, what side? Left Right Both

1. Have you ever worn Foot Orthotics or inserts? YES NO

 If yes, what side? Left Right Both When did you get your last insert? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever worn a Back Brace, LSO or TLSO YES NO

 If yes, what side? Left Right Both How Long? \_\_\_\_\_\_\_\_\_ When did you get your last brace? \_\_\_\_\_\_\_\_

1. Have you ever worn a Leg Brace, AFO or KAFO? YES NO

 If yes, what side? Left Right Both How Long? \_\_\_\_\_\_\_\_\_ When did you get your last brace? \_\_\_\_\_\_\_\_

**Atlantic Prosthetic Services**

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| **PATIENT’S FIRST NAME** | **MI** | **LAST NAME** | **GENDER** |
|  |  |  | m **MALE FEMALE** |

**I TAKE THE FOLLOWING MEDICATIONS**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME OF EACH MEDICATION YOU TAKE DAILY** | **DOSAGE** | **HOW MANY TIMES A DAY?** | **WHY DO YOU TAKE THIS MEDICATION?** | **NAME OF PHYSICIAN WHO PRESCRIBED THIS MEDICATION** |
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**I HAVE HAD PAST SURGERIES:**

|  |  |  |  |
| --- | --- | --- | --- |
| **WHAT TYPE OF SURGERY(S)?** | **WHAT YEARS(S)?** | **NAME OF HOSPITAL(S)** | **NAME OF SURGEONS(S)** |
|  |  |  |  |
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