Excell Orthotics & Prosthetics *Commitment to Excellence*

PATIENT: ____ SEX: ☐ MALE ☐ FEMALE

DOB: ______________ AGE:____________ HEIGHT: ____________ WEIGHT:________________

REFERRING PHYSICIAN: __________________________________PHONE: (_____)_____________

DIAGNOSIS / ICD-9:____________________________________ DATE OF ONSET: _______________

AREA AFFECTED:____ ☐ Left ☐ Right ☐ Spinal

REASON FOR MEDICAL CONDITION: ____

MEDICAL HISTORY **(Please Check All That Apply)**

☐ SKELETAL SYSTEM DISORDER	☐ PARALYSIS	☐ DIABETES
☐ NERVOUS SYSTEM DISORDER	☐ CANCER	☐ HYPERTENSION
☐ SEIZURES	☐ ARTHRITIS	☐ EPILEPSY
☐ HEPATITIS	☐ BALANCE	☐ MUSCULAR DISEASE
☐ OVERWEIGHT	☐ TUBERCULOSIS	☐ LUNG DISEASE
☐ H.I.V. POSITIVE	☐ HEART DISEASE	☐ VASCULAR DISEASE

☐ OTHER MEDICAL PROBLEMS (Please Describe) ____

ADDITIONAL COMMENTS /COMPLAINTS: ____

Previous Device/Equipment History:

Have you had any same or similar device / equipment? ☐ YES ☐ NO

If **YES**, When: ______________________ Where / Facility:___________________________________

Number of years you have worn the orthosis/prosthesis: ___________________

Age of current orthosis/prosthesis: __________________

Describe Condition for Previous Need: ____

Describe New/Changed Condition: ____

If current device needs repair, please describe reason/nature of repairs:

____

The health and personal information contained on the sheet is correct. I agree to the release of this information for purposes of processing health insurance claims.

____ ____________________

Patient Signature (or Parent/Guardian) Date

____ ____________________

Representative/POA (If Patient is unable to sign) Relation to Patient