# MEDICAL ART PROSTHETICS, LLC

## INITIAL PATIENT INTERVIEW FORM

Date: _____ Patient Name: _____

If out of town, local number to be used: _____

Cell phone number: _____

Emergency Contact: _____

Phone Number: _____

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**Introduction**

Age: _____ Race: _____ Sex: _____

Accompanied by: _____

Language Spoken: _____

Referral Source: _____

Purpose of Referral: _____

_____

Diagnosis: _____

History of Illness or Injury: _____

_____

If Injury, was it due to an Auto accident? _____ Place (State) _____

Other accident? _____ Was it work related? _____

Date of accident: _____ Date of onset of symptoms: _____

Initial Occurrence: _____

Course of Treatment (past prosthesis): _____

Surgical History: _____

_____

# MEDICAL ART PROSTHETICS, LLC

## PAST MEDICAL HISTORY

Today's Date: _____

MD: _____ MD Phone: (  ) _____

Please indicate any medical problems:

- ❑ Skin (irritation and rashes)
- ❑ Eye (Glaucoma, Cataracts)
- ❑ Ear
- ❑ Sinus and Respiratory Systems
- ❑ Throat
- ❑ Heart/Circulatory (RH, Fever, murmur, HTN)
- ❑ Liver (hepatitis, mono)
- ❑ Kidney (urinary tract)
- ❑ Bone/joint (arthritis, ortho surg, breaks)
- ❑ Neuromuscular
- ❑ Psychiatric
- ❑ Hematology (anemia, transfusion, clotting)
- ❑ Diabetes
- ❑ Digestive System
- ❑ Tumor (benign/malignant)
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Tobacco use
- ❑ ETOH use (alcohol)
- ❑ Endocrine System (Thyroid)
- ❑ Currently pregnant?
- ❑ Other hosp/Surg/Trauma
- ❑ STD's (herpes/HIV)
- ❑ Medical Allergies

Please explain any of the above (dates, details);

_____
_____
_____
_____

Please list all medications you are currently taking, including any vitamins and herbals. Please include dosage if known.

_____
_____
_____
_____