

MOPRS  
300 Park Avenue  
Portland, ME 04102

PATIENT MEDICAL HISTORY

Accurate answers to the questions below help us serve you safely and professionally.

Patient's Name \_\_\_\_\_  
(Last) (First) (M)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Describe the nature of your medical complaint:

\_\_\_\_\_

\_\_\_\_\_ Right side \_\_\_\_\_ Left Side

Are you a diabetic? \_\_\_\_\_ No \_\_\_\_\_ Yes

Do you ever have any swelling? \_\_\_\_\_ No \_\_\_\_\_ Yes If Yes, When?

Is the complaint or problem related to an accident? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

Was the complaint work-related: \_\_\_\_\_

Exactly when did the problem begin: \_\_\_\_\_

What makes the complaint worse: \_\_\_\_\_

What makes the complaint better: \_\_\_\_\_

Have you ever worn an orthotic device or prosthetic device? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

Do you use any assistive devices? (ie. cane, walker, ramp, etc): \_\_\_\_\_ No \_\_\_\_\_ Yes

Describe the course of treatment you have received to date:

\_\_\_\_\_

\_\_\_\_\_

List any major surgeries pertaining to today's visit and when you had them:

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_