ADVANCED ORTHOPAEDICS AND SPORTS MEDICINE

155 MAIN STREET, MANCHESTER, CT 06042
TELEPHONE (860) 647-1493 FACSMILE (860) 643-6709

NAME ____ **DATE OF SERVICE** ______________________________

D.O.B: ____

Please tell us ***how, when & where*** the first symptoms ***or*** accident occurred? (***Please describe in detail***) ________________________

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Please indicate part of body to be treated ____________________________________ ***(Please specify RT or LT if applicable)***

Have you been treated for this problem? Y / N Where? ______________________________ Dr's name______________________

^^THIS INCLUDES GOING TO YOUR PRIMARY DOCTOR, THE EMERGENCY ROOM, OR WALK-IN CLINIC^^

Have you had X-rays done? Y / N Where were they first taken? ____

MEDICATIONS: Are you currently taking any medication? Y / N ** ***If yes, please fill out SEPARATE medication form****

ALLERGIES: Do you have any allergies? Y/ N ***If yes, what?*** ____

Height______________ Weight__________________ Blood Pressure______________
Pulse _______________ Respiratory _____________ Temp. ____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

YES	*HISTORY*	*NO*
	1. **CARDIOVASCULAR**	
	a. Coronary Disease	
	b. Hypertension	
	c. Arteriosclerosis	
	d. Rheumatic Disease	
	e. History of Bleeding	
	2. **RESPIRATORY**	
	a. Recent URI	
	b. Pneumonia	
	c. Bronchitis	
	d. Bronchiectasis	
	e. Emphysema	
	3. **ENDOCRINE**	
	a. Diabetes	
	b. Thyroid	
	4. **ALLERGY**	
	5. OTHER SYSTEM DIS.	
	6. MEDICATIONS	
	(Give doses and dates)	
	a. Tranquilizers	
	b. Anti-hypertensive	
	c. Insulin	
	d. Digitalis	
	e. Corticosteroids	
	f. Other	
	7.**OPERATIONS**	
	8.**INJURIES**	
	9.**FAMILY HISTORY OF ABOVE**	
	10. **DO YOU SMOKE? How much? ______**	
	11. **DO YOU DRINK? How much? _______**	

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Pedro A. Romero, MD