Ted Manson MD
Towson Orthopaedic Associates

Date: _____ MRN: _____

Name: _____

Date Of Birth: _____

Preferred Phone Number: _____

Preferred Email: _____

Who Referred You to Our Practice? _____

What is your occupation (or what was it if retired)? _____

Do you have:

Diabetes? Yes No If yes what was your last Hemoglobin A1C _____

Heart Problems? Yes No If yes what are they? _____

Kidney Problems? Yes No If yes what are they? _____

Have you ever had a blood clot? Yes No If yes, when? _____

Do you smoke? Yes No _____

Are you allergic to anything? _____

What surgeries have you had?

What Medications do you take?

Any other medical history we should know about?