RMM ORTHOPAEDICS
Specializing in Arthroscopic Surgery and Sports Medicine

PATIENT HISTORY

Patient name: _____ DOB: _____

Have you ever had an allergic reaction to medications, adhesives, injectables, or shellfish? **YES / NO**
Circle one; if yes, please list:

_____ _____
_____ _____

Do you have any history of:

_____High blood pressure	_____Heart Attack	_____Arthritis
_____Frequent headaches	_____Difficulty Breathing	_____Heart Murmur
_____Ulcers/Stomach pain	_____Anemia	_____Cancer
_____Kidney disease	_____Seizures/Epilepsy	_____Excessive bleeding
_____Jaundice/Liver disease	_____Stroke	_____Asthma/Bronchitis
_____Diabetes	_____Fainting spells	_____Blood transfusion
_____Angina	_____Paralysis	_____Thyroid disease
_____Mental Illness	_____Eczema/Psoriasis	_____Sickle cell disease
_____Spinal chord injury	_____Depression	_____Other: _____

Hospitalizations: Date Reason Length of stay

_____
_____
_____

Surgery: Date Procedure Date Procedure

_____ _____
_____ _____
_____ _____

Medications: Please list any medications you are now taking:

_____
_____

If you have ever received a cortisone or steroid injection, please list the body part and the number of times it has been injected.

_____ _____

Social History: (Circle one answer)

Do you now or have you ever smoked cigarettes? **YES / NO**
Have you ever used intravenous or illegal drugs? **YES / NO**
Do you drink alcohol? **YES / NO**
Would you be opposed to receiving blood transfusion should it be necessary during your care? **YES / NO**

If there are any other conditions which you feel we should address please describe below:

_____
_____

Patient Signature: _____ **Date:** _____