RICHARD KIM
MEDICINE

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PATIENT HISTORY

Primary Care Physician: ____

Allergies to Medications ____

Current Height: __________ Current Weight: __________

Past Medical History

Please check any that apply and list diagnosis:	Please list any additional diseases you are actively being treated for
☐ Heart Disease ______________________	1. ______________________ ______________________
☐ Lung Disease ______________________	2. ______________________ ______________________
☐ Kidney Disease ______________________	3. ______________________ ______________________
☐ Liver Disease ______________________	4. ______________________ ______________________
☐ Stomach or Colon Disease ______________________	5. ______________________ ______________________
☐ Blood Disorders ______________________	
☐ Eye, Ear, Nose, Throat Disease ______________________	
☐ Skin Disease ______________________	
☐ Neurologic or Psychiatric Disease ______________________	

Past Surgical History

- Please list all orthopedic surgeries, surgeon performed by, and date

  ____

  ____

  ____

- Please list all other surgeries

  ____

  ____

  ____

Social History	**Family History of Diseases**
Alcohol Consumption How much and how often ____________ Tobacco Use Type of tobacco _______________ How much and how often _____________	1. _______________________ 2. _______________________ 3. _______________________ 4. _______________________ 5. _______________________

Review of Systems
Please check all that apply:

General	**Ear Nose and Throat**	**Lymph**
☐ Fatigue ☐ Decreased appetite ☐ Fevers ☐ Weight Loss ☐ Weight Gain ☐ Insomnia	☐ Visual Changes ☐ Hearing Loss ☐ Sore Throat ☐ Nasal Congestion ☐ Runny Nose ☐ Ear Pain	☐ Swollen glands in neck, armpits, or groin
Respiratory ☐ Shortness of Breath ☐ Cough ☐ Wheeze	**Cardiovascular** ☐ Chest Pain ☐ Palpitations ☐ High blood pressure ☐ Stroke	**Gastrointestinal** ☐ Abdominal pain ☐ Constipation ☐ Bloody stool ☐ Diarrhea ☐ Heartburn ☐ Nausea/Vomiting
Genitourinary ☐ Change in bowel habits ☐ Painful urination ☐ Bloody urine ☐ Increased frequency	**Gynecologic** ☐ Irregular menses ☐ Abnormal discharge ☐ Pelvic pain	**Skin** ☐ Rash ☐ Itching ☐ Ulcers

Neurologic	**Other:**
☐ Headaches ☐ Dizziness ☐ Numbness or tingling	____________________ ____________________ ____________________

Medications

Please List All Medications, Dosages and Frequencies:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________