RICHARD KIM MEDICINE

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PATIENT MEDICAL HISTORY

Last Name_____First Name_____Middle_____

Date of Birth_____Current Height_____ Current Weight_____ Occupation:_____

Primary reason for appointment(list single problem here)_____

How long have you had this problem?_____Have you received treatment?_____

Have you had any of the following and if yes please document date had procedure(s):
X-Ray: __Yes __ No (Date:_____)MRI: __Yes __No(Date_____) Injection: __Yes __No(Date_____)
Prior surgery: __Yes __No(Date_____)Physical Therapy: __Yes__ No(Date_____)
(If yes to any of imaging/injections/surgery, please have records sent before appointment)

Please list all current medications and dosage: (Attach List if needed)

_____

_____

Are you on any blood thinners? Y__N--
Please list any allergies_____
Are you allergic to Latex? Y__N__

PAST SURGICAL HISTORY (Please list all orthopedic surgeries, surgeon performed by and date"

_____

_____

_____

Please List All Other Surgical History:_____

_____

SOCIAL HISTORY:
Alcohol Consumption? Y__N__ Frequency: daily__ Social__Quantity__Occasionally__
Tobacco Use? Y__N__ If Yes, __Daily __Occasionally Do you live in a smoke-free home? Y__N__

FAMILY HISTORY OF DISEASES_____

_____

Please check that apply and list diagnosis:

___Blood Disorders_____
___Eye, Ear, Nose, Throat Disease_____
___Heart Disease_____,_____
___Kidney Disease_____
___Other Medical Problems not listed above_____
___Liver Disease_____
___Lung Disease_____
___Skin Disease_____
___Stomach or Colon Disease_____
_____

TURN PAGE OVER-MORE INFORMATION NEEDED

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Review of Systems

Please check all that apply:

General □ Fatigue □ Decreased appetite □ Fevers □ Weight Loss □ Weight Gain □ Insomnia	**Ear Nose and Throat** □ Visual Changes □ Hearing Loss □ Sore Throat □ Nasal Congestion □ Runny Nose □ Ear Pain	**Lymph** □ 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 □ Headaches □ Dizziness □ Numbness or tingling	**Other:** _____ _____	

I, certify that this information is to the best of my knowledge and believe is true, correct and complete.

_____ _____

Patient or Guardian Signature Date

I give Richard Kim M.D., permission to release medical information to the above referring physician.

_____ _____

Patient or Guardian Signature(Sign only if sending records) Date

AUDIO AND VIDEO RECORDING POLICY: I, the patient or patient's representative, agree to refrain from audio and or video recording of this and any interaction held between, myself as the patient or representative, with Richard Kim Medicine. For the explicit reason of quality, safety, and HIPAA compliance I understand that the nature of recordings, either visual and/or audio, can be manipulated, misconstrued, and misinterpreted. Therefore, I, as the patient or as the patient's representative, understand that failure to acknowledge and sign to this agreement may result in termination of physician/patient relationship. I am, however, eligible to obtain a copy of the paper medical records, in its entirety.

_____ _____

Parent or Guardian Signature Date

Check out our website by scanning the code for more information or go to richardkimmedicine.com