

Tiffani Kim Institute Medical History

Patient: _____ Male Female Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, please list allergies below:
 1. _____ 2. _____

Are you allergic to nickel? YES NO

List all Medications you are currently taking:

1. _____ 2. _____
 3. _____ 4. _____

Past Medical History/Have you had any of the following (please check all that apply):

- | | | |
|------------------------------------------------------|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Heart Disease/Murmur/Angina | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other _____ | |

Do you drink alcohol? YES NO If YES _____ drinks per day

Do you use IV drugs? YES NO If YES, what? _____ How much and how often? _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Have you ever had dental anesthesia (Novacaine)? YES NO Any bad reaction? YES NO

Skin:

When you are exposed to sun do you: Tan only Tan and burn Burn

Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO If YES, who? _____

Do you have a history of any specific skin diseases? YES NO

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

Do you smoke? YES NO If YES, how much? _____ per day

Do you bleed easily? YES NO

Are you pregnant? YES NO N/A Due Date: _____

Do you have artificial joint(s)? YES NO

What is your occupation? _____

What are your hobbies? _____

Completed by: Patient
 Medical Assistant _____
Initials Reviewed by