

ROY KIM, MD
Plastic and Reconstructive Surgery
Hand and Microvascular Surgery
www.drkim.com

Patient History & Medications

Patient Name: _____

Date: _____

Allergies to Medications

Medications Currently Taking (please list the physician who prescribed the medication)

Medical Illnesses

Previous Surgical Procedures (please list the approximate year of the surgery)

**Do you currently smoke? Y N If so, please list how much you smoke
a day and for how many years _____**

**Have you ever smoked? Y N If so, please list how much you used to
smoke a day and for how many years _____**

**Do you drink alcohol? Y N If so, please list what you drink and your
amount of consumption _____**