

BRIAN D. COHEN, M.D., P.L.L.C.

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NEW YORK, NY 10028
212-472-4700

MEDICAL HISTORY FORM

Name: _____
Age: _____ Sex: M/F Height: _____ Weight: _____ (Is your weight stable? Y/N)

Why are you here to see Dr. Cohen?

Please list ALL medical conditions:

Please list all prior surgical procedures:

DATE

_____	_____
_____	_____
_____	_____

Family History: Diabetes Stroke Heart Disease Aneurysm Cancer NONE
If so, please describe: _____

MEDICAL QUESTIONNAIRE:

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in good health? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any changes in your health in the past year? If so, please explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had rheumatic heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had damaged heart valves, artificial valve or heart murmur? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had chest pain or shortness of breath with mild exertion? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have lung disease, asthma, bronchitis, emphysema, tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had fainting spells or seizures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have migraine headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have liver disease, hepatitis, jaundice? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have thyroid problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a stomach ulcer or hyperacidity? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have diarrhea or constipation? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a hernia? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had seizures or a stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of kidney problems, stones, urinary track infections? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any blood disorders, anemia, abnormal bleeding, blood transfusions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a blood clot? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a "collagen disease" (eg, Lupus, Rheumatoid Arthritis, Raynaud's disease)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have persistent swollen neck glands? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for a growth or tumor? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any history of cancer? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any history of radiation therapy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any history of cold sores? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any history of keloid scarring? |

- Do you have any history of poor wound healing?
- Do you take steroids?
- Have you ever had a problem with general anesthesia?
- Do you drink alcohol on a regular basis? If so, how much? _____
- Do you smoke? If so, how many cigarettes per day and for how long? _____
- If you were a smoker at one time, when did you quit? _____

WOMEN:

Number of pregnancies: _____ Births: _____ C-sections: _____ Miscarriages: _____

- YES NO
- Are you pregnant or trying to become pregnant?
- Do you have problems associated with your menstrual period?
- Are you nursing?
- Are you taking birth control pills?

Date of last mammogram? _____

ALLERGIES:

- YES NO
 - Are you allergic to latex?
 - Are you allergic to any medications?
- If yes, please list all medications that you are allergic to and REACTION:

Medication	Reaction

MEDICATIONS:

- YES NO
- Have you ever taken weight reduction (diet) pills?
- Do you take aspirin, Plavix, Coumadin or any other blood thinner?

Please list ALL medications that you currently take including vitamins and over the counter medications (continue on back of form if necessary):

Medication	Dose	Frequency

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____
Parent or Guardian's Signature: _____
Date: _____ **Relationship** _____