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

560 NORTHERN BOULEVARD, SUITE 209
GREAT NECK, NY 11021
516-773-4200

50 EAST 69TH STREET
NEW YORK, NY 10065
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 QUESTIONAIRE:

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

☐ ☐ 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: ____
Relationship

Date: ______________