Gregory S. Cohn, M.D.
7301A W. Palmetto Park Road, Suite 202C
Boca Raton, FL 33433
(561)367-7447

Patient's Medical History Questionnaire

Date:_____
Name:_____Date of Birth:_____Sex:_____
Local Address:_____
Permanent(Summer) Address, if different than above_____
_____
Local Phone #_____Cell Phone #_____
Work Phone #_____Summer Phone #(if different)_____
Email address_____

Were you referred by a physician?_____Referring Physician Name:_____
Referring Physician Phone #_____Address:_____

Occupation:_____Employer:_____
Employer's Address:_____
If unemployed, last date of employment_____Are you disabled:_____
Spouse's occupation_____Work Phone #_____

Number of Children_____Ages_____

What is the chief problem that brings you to my office?_____
_____
How long have you had the problem?_____
What do you think might be causing it?_____
_____

Past Medical History

Hospitalizations:

Year Diagnosis Operation (if any)

_____
_____
_____
_____
_____

Other Serious Illnesses:

Year Diagnosis

_____
_____
_____
_____

Allergies: List all medicines and other substances to which you are allergic

_____
_____

Medicines: List all medicines that you have been taking recently. (Please include all vitamins and non-prescription medicines as well as prescribed medicines).

Please bring all medications with you.

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Immunizations:

Pneumonia Vaccine_____(date) Tetanus_____(date)

History: List parents and all brother and sisters, if deceased, please list age and cause of death.

	Living? Current Age or date of death	State of Health or Cause of Death
Mother		
Father		

Is there a family history of any of the following in a blood relative? Please check.

____alcoholism _____high blood pressure _____diabetes _____cholesterol problems
_____colon cancer _____ breast cancer _____prostate cancer _____other cancer
_____stroke _____kidney stones or failure ____heart attack before 60_____depression

Personal Habits:

Tobacco (type and amount per day)_____
If not smoking now, have you smoked in the past?_____
Alcohol (amount per day or week)_____
Have you had a problem with alcohol?_____
Coffee, Tea, and Cola Beverages (cups per day)_____
Special Diet_____

Activity Level:

Independent with all daily activities _____Yes _____No
Requires special assistance or equipment _____Yes _____No Explain_____
Completely Dependent _____Yes _____No

Do you have any of the following?

		Yes	**No**
1	Recent weight gain? (_____ pounds)		
2	Recent weight loss? (_____pounds)		
3	Fever of soaking sweats at night?		
4	Fatigue?		
5	Weakness or numbness of arms or legs?		
6	Headaches more than once or twice a week?		
7	Difficulty walking?		
8	Loss of consciousness or convulsions?		
9	Do friends or family ask you to repeat what you say?		
10	Do you have difficulty completing your thoughts?		
11	Problem with vision that is not corrected with glasses?		
12	Change in hearing?		
13	Ringing in your ears?		
14	Dizziness?		
15	Frequent or severe nosebleeds?		
16	Trouble chewing or swallowing?		
17	Sore tongue or mouth?		
18	Neck pain or stiffness?		
19	Daily cough?		
20	Short of breath after walking up two flights of stairs?		
21	Short of breath when just sitting or lying down?		
22	Discomfort in the chest?		
23	Swelling of the ankles everyday?		
24	Pain in the legs while walking?		
25	High blood pressure?		
26	Abdominal pain?		
27	Frequent heartburn or indigestion?		
28	Change in bowel movements?		
29	Black or bloody bowel movements?		
30	Recent change in your appetite?(explain)		
31	Nausea, vomiting, diarrhea for more than 5 days?		
32	Bloody or otherwise unusual appearing urine?		
33	Difficulty urinating?		
34	Do you lose control of urine at times?		
35	Awaken at night more than once to urinate?		
36	Any skin problems at this time?		
37	Persistent pain in joints?		

		Yes	No
38	Back pain?		
39	Do you enjoy your work?		
40	Frequent conflicts at home?		
41	Sexual problems?		
42	Do you feel anxious or depressed much of the time?		
43	Have you seriously considered suicide?		
44	Difficulty in sleeping?		
45	History of hospitalization for an emotional problem?		

	WOMEN ONLY:		
47	Are menstrual periods normal?		
48	Date of last menstrual period?		
49	Any Vaginal discharge?		
50	Pregnancies_____ Deliveries_____		
51	Bleeding between periods or after menopause?		
52	Approximate date of last PAP smear?		

Have you ever had?

	Asthma		
	Diabetes		
	Heart Murmur		
	Heart Attack		
	Hepatitis or Liver Disease		
	Kidney Stones		
	Phlebitis		
	Pneumonia		
	Polio		
	Rheumatic Fever		
	Stroke		
	Thyroid Trouble		
	Tuberculosis		
	Ulcer		

Other serious illnesses not mentioned above. Please list below:

_____
_____
_____
_____

Signature of Patient _____

Reviewed by/Date_____