The Internal Medicine Offices of
PAUL S. COHEN MD

PATIENT HEALTH HISTORY QUESTIONNAIRE

Referring physician _____

List other physicians _____ _____

_____ _____

Patient name _____

Date of birth _____ Today's Date _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

FAVORITE PHARMACIES/ LOCAL + MAILORDER

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐ Chickenpox	Date:_____	☐ Meningococcus	Date:_____
☐ Flu Shot	Date:_____	☐ MMR (*Measles, Mumps, Rubella)*	Date:_____
☐ Gardasil/HPV	Date:_____	☐ **Pneumovax 23**	Date:_____
☐ Hepatitis A	Date:_____	☐ Tdap (*Tetanus and pertussis)*	Date:_____
☐ Hepatitis B	Date:_____	☐ Tetanus	Date:_____
		☐ Zostavax (*Shingles)*	Date:_____
		☐Prevnar 13	Date_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal

Last Mammogram Date _____ ☐ Abnormal

Bone Density testing_____

date + location of testing

Patient name _____

Date of birth _____ Today's Date _____

PAST MEDICAL HISTORY

Check all that apply:

- ☐ ADHD
- ☐ AIDS/HIV
- ☐ ANEMIA
- ☐ Anesthesia Complications
- ☐ ANXIETY DISORDER
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ Bladder or Kidney Problems
- ☐ Blood Transfusion
- ☐ Cancer-BREAST
- ☐ Cancer-CERVICAL
- ☐ Cancer-COLON
- ☐ Cancer-LUNG
- ☐ Cancer-OTHER
- ☐ Cancer-Ovarian
- ☐ Cancer-Prostate
- ☐ Cancer-Skin
- ☐ Cancer-Uterine
- ☐ Chicken Pox
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Ear or Hearing Problems
- ☐ GI Problems
- ☐ GOUT
- ☐ HEADACHES
- ☐ HEART PROBLEMS
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ Muscle, Joint, or Bone Problems
- ☐ Osteoporosis
- ☐ Pulmonary Embolism
- ☐ Seizure/Epilepsy
- ☐ Skin Problems
- ☐ Stroke
- ☐ ADHD
- ☐ Thyroid Problems
- ☐ Vision or Eye Problems

PAST SURGICAL HISTORY

***INCLUDING MOST RECENT COLONSCOPY*

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			

FAMILY HEALTH HISTORY

Health Problem	**Family Members** (Please list each member and age at diagnosis)
Alcoholism	
Arthritis	
Depression	
Cancer	
Diabetes	
Heart Disease	
Hypertension	
Osteoporosis	
Stroke	
Other_____	

SOCIAL HISTORY

Occupation

_____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level
- ☐ None (No exercise)
- ☐ Occasional exercise
- ☐ Moderate exercise
- ☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? _____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
- ☐ Cigarettes - _____pks./day
- ☐ Chew - _____/day
- ☐ Cigars - _____/day
- ☐ # of years_____

Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:

_____

_____