

Greg S. Cohen, MD
Northwestern University Feinberg School of Medicine
Department of Medicine – Division of Gastroenterology
676 North St. Clair Street Suite 1525
Chicago, IL 60611 (312) 695 – 4452

The following information will become part of your confidential medical record

Date/Time of First Appointment ____/____/____ at ____ m.

Name: _____ Birthdate: ____/____/____
LAST FIRST MIDDLE INITIAL

HISTORY OF ILLNESS

(Please describe the problems you are having):

PAST MEDICAL HISTORY

(Please list all medical problems, past surgeries, and hospitalizations including dates and hospital names):

CURRENT MEDICATIONS:

Name of Medication	Dosage	Start Date	Prescribed by
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ALLERGIES:

Name of Medication	Reaction
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SOCIAL HISTORY

Sex : Male Female Education level: _____ Ethnicity: _____

Marital Status: Single Married Widowed Divorced (Children if yes, how many _____)

Interest/Hobbies: _____

Alcohol use: Never Former when did you stop? Occasional Daily

Tobacco use: Never Former when did you stop? Current

Cigarettes: _____ Cigars: _____ Chewing Tobacco: _____

Illicit drugs: (explain)

FAMILY HISTORY

Is there any family history of colon cancer? Circle One Y N

Is there any family history of liver disease? Circle One Y N

List below any cases of cancer, peptic ulcer, Crohn's disease, ulcerative colitis, gall bladder disease, liver, hereditary conditions, or other significant conditions: (e.g., heart disease, hypertension, diabetes, etc.)

	If deceased, cause of death	Age
Parents _____	_____	_____
Brothers/Sisters _____	_____	_____
Grandparents _____	_____	_____

OCCUPATIONAL HISTORY

Current Employment _____

Past Employment _____

REVIEW OF SYSTEMS AND SYMPTOMS

Please ✓ the following symptom/disease you've recently had or now have.

Constitutional

- Recent Weight Loss/Amount _____
- Recent Weight Gain/Amount _____
- Fever
- Fatigue
- Weakness
- Change in appetite
- Special Diet for Medical Condition
- Other _____

Ears

- Hearing loss
- Hearing aid
- Ear pain
- Ear ringing
- Other _____

Throat

- Frequent sore throat
- Difficulty swallowing
- Hoarseness
- Other _____

Nose

- Frequent discharge
- Nose bleeds
- Other _____

Mouth

- Ulcers/sores
- Loss of taste
- Full/partial dentures
- Other _____

Eyes

- Blurred or double vision
- Loss of sight
- Glasses
- Pain
- Other _____

Allergic/Immunologic

- Allergies/not medication
- Abnormal immune system
- HIV / AIDS
- Other _____

Lungs/Respiratory

- Shortness of breath
- Asthma
- Wheezing/Cough
- Abnormal Chest x-ray
- Night Sweats
- Tuberculosis
- Other _____

Genitourinary

- Urinary tract infection
- Blood in urine
- Burning with urination
- Difficult urination
- Kidney stones
- Sexual difficulties
- Prostate trouble
- Other _____

Psychiatric

- Depression
- Past evaluation/treatment
- Other _____

Musculoskeletal

- Arthritis
- Joint swelling
- Lupus, scleroderma or related
- Joint pain
- Back pain
- Muscle weakness/pain
- Other _____

Skin

- Dermatitis/rash/hives
- Jaundice/yellow skin
- History of Mammogram
- Breast cancer
- Itching
- Psoriasis
- Nodules/bumps
- Bruise easily
- Other _____

Hematologic/Lymphatic

- Swollen glands
- Blood disease
- Anemia
- Abnormal blood count
- Bruise easily
- Blood transfusion when? _____
- Other _____

Abdominal/Gastrointestinal

- Diarrhea
- Vomiting blood
- Vomiting
- Constipation
- Crohn’s disease
- Ulcerative colitis
- Inguinal hernia
- Esophageal reflux
- Irritable bowel syndrome
- Ulcers
- Abdominal Pain
- Indigestion
- Nausea
- Bloating
- Difficulty swallowing food
- Gallstones
- Rectal Bleeding
- Hepatitis/liver disease
- Hemorrhoids
- Belching – gas
- Colitis
- Inflammatory bowel disease
- Heartburn
- Other _____

Endocrine

- Diabetes
- Thyroid disease
- Post-menopausal
- Other _____

Cardiovascular

- Chest pain
- Mitral valve prolapse
- Ankle/leg swelling
- Pacemaker
- History of heart attack
- Irregular heart beat
- Palpitations
- High blood pressure
- Other _____

Neurological

- Memory loss/Confusion
- Seizure disorder
- Tremors
- Dizziness
- Headaches
- Fainting
- Other _____

Date of last eye exam? _____

Menstrual:

Age when periods began: _____ regular? _____
 Date of last period _____
 Date of last pap smear _____
 Bleeding after menopause? _____

Are outside medical records available?

Circle one Y N

Patient’s Signature: _____ Date: _____

Physician Signature: _____ Date: _____