# Shariar Cohen, M.D. Corp.

**Shariar Cohen-Gadol, M.D.**

558 St. Charles Drive Ste. 110

Thousand Oaks, CA 91360

Phone: (805) 449-8781  Fax: (805) 449-4224


## HEALTH QUESTIONNAIRE

Name: _____ DOB: _____ Today's Date: _____

**Please give a brief Rheumatologic history including your chief complaint, the onset, current symptoms, any triggers to those symptoms, and any alleviations.**

_____

_____

_____

_____

_____

_____

_____

_____

**Please provide a brief previous medical history including previous diagnoses, major surgeries or major illnesses along with the dates and treatments (if possible).**

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

**Please list any hospitalizations you have had along with the reason, date, and treatments.**

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

**Please list your current medications including the daily dosage.**

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

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**Please list any drug <u>ALLERGIES</u> that you have and the reaction that occurred:**

1. _____ 2. _____

3. _____ 4. _____

**<u>Please circle the following medications that you have tried in the past:</u>**

| | | | |
|---|---|---|---|
| Actemra | Cyclosporine | Motrin | **<u>Joint Injections with:</u>** |
| Actonel | Cytoxan | Naprelan/Naproxen | Cortisone |
| Allopurinol | Enbrel | Orencia | Euflexxa |
| Arava/Leflunomide | Feldene | Plaquenil | Hyalgan |
| Arthrotec | Fosamax | Prednisone | Orthovisc |
| Aspirin | Gold Injection | Prolia | Supartz |
| Benlysta | Humira | Reclast | Synvisc |
| Boniva | Imuran | Relafan | |
| Celebrex | Indocin | Remicade | |
| Cellcept | Kineret | Rituxan | Other: |
| Cimzia | Lodine/Etodolac | Simponi | |
| Colchicine | Methotrexate | Uloric | |
| Cortisone | Mobic | Voltaren | |

**<u>Please provide any family history of Rheumatic disease.</u>**

Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____
Relative: _____ Diagnosis: _____

**<u>Social History:</u>**

| | | | |
|---|---|---|---|
| Do you exercise? | YES | NO | What type and how often? _____ |
| Do you consume alcohol? | YES | NO | If yes, how much per week? _____ |
| Do you smoke? | YES | NO | If yes, how many per week? _____ |
| Do you use any other drugs? | YES | NO | If yes, **what kind**, **how often**, **how many years**? _____ |
| | | | _____ |

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## Review of Systems

Circle the symptoms that you are currently experiencing.

**GENERAL:**
Fatigue
Fever
Chills or night sweats
Weight loss due to illness
Anxiety
Depression

**SKIN:**
Facial rash
Psoriasis
Skin ulcers
Bruises
Hair loss
Raynaud's (fingertip color change)
Skin tightening
Itching
Sun sensitivity

**HEAD AND NECK:**
Pain (specify location): _____
Dry eyes
arthritis
Conjunctivitis
Redness
History of Iritis
Ringing in the ears
Mouth sores
Dry mouth
Salivary gland enlargement
Memory loss
Lymph node enlargement

**HEART AND LUNG:**
Palpitations, irregular heartbeat
Murmur
Pleurisy
Wheezing or persistent cough
Chest pain or shortness of breath
Hypertension
High cholesterol or triglycerides

**STOMACH AND BOWELS:**
Loss appetite
Difficulty swallowing
Peptic ulcers
Heartburn
Abdominal pain
Nausea/vomiting
Tarry stool or hemorrhoids
Jaundice or hepatitis
Diarrhea or colitis or diverticulitis

**KIDNEYS/BLADDER:**
Burning with urination
Urethral  discharge
Blood in urine
Protein in urine
Kidney stone(s)
Chronic kidney/bladder infection

**NERVOUS SYSTEM & MUSCLES:**
Seizures or convulsions
Tingling or burning

Pain or weakness
Blackout

**JOINT HISTORY:**
Pain or swelling

| | | |
|---|---|---|
| Jaw | Wrists | Ankles |
| Neck | Knuckles | Toes |
| Shoulders | Hips | Fingers |
| Elbows | Knees | |

Heat or redness
Morning stiffness

**BACK:**
Pain or stiffness (specify location): _____
Spinal injury
Pain that interferes with sleep
Pain radiating from back to buttock or leg(s)

**METABOLIC:**
Diabetes
Thyroid disease
Goiter
Adrenal disease
Obesity

**BLOOD:**
Anemia
Low white blood count
Low platelet count
Previous transfusion(s)
Low iron

**DAILY ACTIVITIES:**
Trouble feeding myself
Trouble dressing/grooming myself
Trouble using the bathtub
Trouble doing housework
Trouble driving
Intercourse difficult due to arthritis
Intercourse impossible due to

**WOMEN ONLY:**
Irregular menstrual cycles?_____
Last menstrual cycle: _____
Number of pregnancies: _____
Number of miscarriages: _____
Last PAP Smear: _____
Last mammogram: _____