



ISSAM A. HALABY, MD  
GENERAL & VASCULAR SURGERY

436 Nokomis Avenue South · Venice, FL 34285 · Office 941-445-5054 · Fax 941-303-6796

***Patient History Questionnaire - Please complete & bring to your appointment.***

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_ Sex M F Date: \_\_\_\_\_  
Referring physician: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
Primary Dr: \_\_\_\_\_ Cardiologist \_\_\_\_\_  
Other Doctors \_\_\_\_\_

Race: *(Circle One)* White Am. Indian/AK Native Asian Black/African Am. Nat. Hawaiian Other Race Declined

Ethnicity: *(Circle One)* Hispanic or Latino Non-Hispanic or Latino Declined

**HISTORY OF PRESENT ILLNESS**

**Reason for your visit:** \_\_\_\_\_

◆ Location of Problem: \_\_\_\_\_ Duration: \_\_\_\_\_  
*(Where on the body symptom occurs- Right or Left side if applicable) (How long have you had symptom? How long does it last?)*

◆ Severity: \_\_\_\_\_ Quality: \_\_\_\_\_  
*(Severe, worse, slightly. Pain scale 1-10) (Character of symptom...burning, gnawing, stabbing)*

◆ Timing: \_\_\_\_\_ Context: \_\_\_\_\_  
*(When symptoms occur) (Situation associated with symptom)*

◆ Modifying Factors: \_\_\_\_\_  
*(Things that make symptoms better or worse)*

◆ Associated Signs/Symptoms: \_\_\_\_\_  
*(Other things that happen when this symptom occurs)*

**Medical History:** *Please circle Yes or No if you have the following medical problems & explain below.*

High Blood Pressure ...Yes No Respiratory Problems ...Yes No >Type \_\_\_\_\_  
Diabetes .....Yes No Bleeding Problems. ....Yes No>Type \_\_\_\_\_  
Stroke.....Yes No Heart Trouble.....Yes No> Type \_\_\_\_\_  
Cancer.....Yes No >> Type \_\_\_\_\_  
Other Problems \_\_\_\_\_

What is your current weight? \_\_\_\_\_ Height \_\_\_ Feet \_\_\_ Inches  
Preferred Pharmacy \_\_\_\_\_ Location/Phone \_\_\_\_\_

**Current Medications/Dosage:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Drug Allergies: \_\_\_\_\_  
Are you allergic to contrast dye? Yes No

***Please Continue to Reverse Side***



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**Past Hospitalizations/Surgeries/Injuries and Approximate Dates:**

\_\_\_\_\_  
\_\_\_\_\_

**Family History:** *Please list any medical problems in your relatives.*

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_ Other \_\_\_\_\_

**Social History:** Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never Quit/ What age? \_\_\_\_\_ Smoker/ how much? \_\_\_\_\_

Alcohol Use: Never Rarely Moderate Daily How much? \_\_\_\_\_

Recreational Drug Use: Never Type and frequency \_\_\_\_\_

Occupation: \_\_\_\_\_ Permanent Resident? Yes No

Review of Systems *Please circle Yes or No if you have any of the following problems.*

<b>Constitutional</b>	<b>Ears/Nose/Mouth/Throat</b>	<b>Eyes</b>
Good General Health Yes No	Hearing loss or ringing Yes No	Wear glasses/contacts Yes No
Recent weight change Yes No	Sinus problems Yes No	Blurred/double vision Yes No
Night sweats, fevers Yes No	Nose bleeds Yes No	Eye disease or injury Yes No
Fatigue Yes No	Sore throat/voice change Yes No	Glaucoma Yes No

<b>Cardiovascular</b>	<b>Respiratory</b>	<b>Gastrointestinal</b>
Chest pain Yes No	Shortness of breath Yes No	Nausea/vomiting Yes No
Palpitations Yes No	Cough Yes No	Abdominal pain Yes No
Heart trouble Yes No	Wheezing/asthma Yes No	Rectal bleeding Yes No
Swelling hands/feet Yes No	Coughing up blood Yes No	Bowel problems Yes No

<b>Musculoskeletal</b>	<b>Neurological</b>	<b>Integumentary (Skin/Breast)</b>
Muscle pain or cramp Yes No	Frequent headaches Yes No	Change in hair or nails Yes No
Stiffness/swelling joints Yes No	Paralysis or tremors Yes No	Rashes or itching Yes No
Joint pain Yes No	Convulsions/seizures Yes No	Breast lump Yes No
Trouble walking Yes No	Numbness/tingling Yes No	Breast pain/discharge Yes No

<b>Endocrine</b>	<b>Hematologic / Lymphatic</b>	<b>Allergic/Immunologic</b>
Excessive thirst/urination Yes No	Bruise easily Yes No	Food allergies Yes No
Thyroid disease Yes No	Slow to heal Yes No	Aspirin allergies Yes No
Hormone problem Yes No	Enlarged glands Yes No	Antibiotic allergies Yes No

<b>Genitourinary -Male only</b>	<b>Genitourinary -Female only</b>	<b>Psychiatric</b>
Blood in urine Yes No	Blood in urine Yes No	Insomnia Yes No
Kidney stones Yes No	Kidney stones Yes No	Confusion/memory loss Yes No
Sexual problems Yes No	Sexual problems Yes No	Depression Yes No
Testicle pain Yes No	Menstrual problems Yes No	Other _____

<p><b>Patient statement: To the best of my knowledge, the above information is accurate and complete.</b></p> <p>Signed _____ Date _____</p>
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