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.*

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
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

Cardiovascular			**Respiratory**			**Gastrointestinal**		
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

Musculoskeletal			**Neurological**			**Integumentary (Skin/Breast)**		
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

Endocrine			**Hematologic / Lymphatic**			**Allergic/Immunologic**		
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

Genitourinary -Male only			**Genitourinary -Female only**			**Psychiatric**		
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 _____		

Patient statement: To the best of my knowledge, the above information is accurate and complete.

Signed _____ Date_____

Revised 09/14/2023

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