Dr. Avi Ishaaya
MD, FCCP, FAASM, FACGS, MACGS

Patient Health & Medical History Questionnaire

Date:____/____/____ Patient Name:_____

D.O.B.____/____/____ Age:_____ Height:_____ Weight:_____lbs Race:_____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Care Physician: _____ Referring Physician: _____

Past Medical History: Please answer all questions to the best of your ability.
Do you now or have you ever had:

Tuberculosis	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Stomach Disease	☐ Yes ☐ No
Diabetes (Blood sugar high or low)	☐ Yes ☐ No	Intestinal Disease	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Peptic Ulcer	☐ Yes ☐ No
Other Heart Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Seizure	☐ Yes ☐ No

Please explain all "YES" answers: _____

_____

Habits
Do you now or have you ever used/consumed:

1. Tobacco (smoking, chewing, etc) ☐ Yes ☐ No If yes, indicate amount per day: _____
If yes, how long? _____years Have you quit? ☐ Yes ☐ No If yes, when? _____

2. Alcohol (beer, liquor, wine, etc) ☐ Yes ☐ No If yes, indicate amount per day: _____
If yes, how long? _____years Have you quit? ☐ Yes ☐ No If yes, when? _____

3. Caffeinated beverages (soda, coffee, tea, etc) ☐ Yes ☐ No If yes, indicate amount per day: _____
Have you quit? ☐ Yes ☐ No If yes, when? _____

Medications

Please list all medications you are currently taking. _____

_____

Allergies

Please list allergies to medication. _____

_____

Surgeries

Please list any operations you have had or will have:

Type:	Date:	Hospital:	Doctor:

Current Medical History

Do you have:

Frequent or severe headaches	☐ Yes ☐ No	Frequent cough	☐ Yes ☐ No
Difficulty breathing through nose	☐ Yes ☐ No	Chronic nasal discharge	☐ Yes ☐ No
Painful sinuses	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Allergies/ Hayfever	☐ Yes ☐ No	Asthma or wheezing	☐ Yes ☐ No
Dentures	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Smothering spells at night	☐ Yes ☐ No	Swollen legs	☐ Yes ☐ No
Irregular heart beat	☐ Yes ☐ No	Heart enlargement	☐ Yes ☐ No
Chest pain during/after exercise	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No
Difficulty swallowing	☐ Yes ☐ No	Hiatal hernia	☐ Yes ☐ No
Voice change / hoarseness	☐ Yes ☐ No	Do you sleep on more than one pillow?	☐ Yes ☐ No
Chronic Muscular Pain	☐ Yes ☐ No	Pain in joints	☐ Yes ☐ No
Localized muscle weakness	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Goiter or thyroid enlargement	☐ Yes ☐ No	High blood sugar	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Weight gain	☐ Yes ☐ No	Low blood sugar	☐ Yes ☐ No
Low blood pressure	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No

History of Stroke	☐ Yes ☐ No	Personality changes	☐ Yes ☐ No
Memory loss	☐ Yes ☐ No	Diagnosed depression	☐ Yes ☐ No
Difficulty moving or controlling parts of the body	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Tremors or shakes in your arms or legs	☐ Yes ☐ No	"Drop" or paralysis attacks	☐ Yes ☐ No

Please explain all "Yes" answers: _____

_____

_____

_____

_____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number rating for each situation.

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

1. Sitting and reading	○ 0	○ 1	○ 2	○ 3
2. Watching TV	○ 0	○ 1	○ 2	○ 3
3. Sitting, inactive in a public place	○ 0	○ 1	○ 2	○ 3
4. As a passenger in a car for an hour without a break	○ 0	○ 1	○ 2	○ 3
5. Lying down to rest in the afternoon when circumstances permit	○ 0	○ 1	○ 2	○ 3
6. Sitting and talking to someone	◉ 0	○ 1	○ 2	○ 3
7. Sitting quietly after lunch (without alcohol)	○ 0	○ 1	○ 2	○ 3
8. In a car, while stopped for a few minutes in traffic	○ 0	○ 1	○ 2	○ 3

Total Epworth Score 0

Patient Information

Name _____ Date _____

Gender: ❒Female ❒ Male Marital Status: ❒Single ❒Married ❒ Divorced ❒Widowed

Social Security #_____ Date of Birth _____

Address _____ Unit # _____

City _____ State _____ Zip _____

Home Telephone _____ Work _____

Cell Phone# _____ Fax #_____

Email address _____

Pharmacy Name: _____Tel #_____

I hereby request and authorize that confidential communications about my medical information or medical records be communicated to me using:

- **Text messaging to cell number_____**
- **Email:_____**
- **Fax:_____**

Medical Insurance Information

Insurance Co. Name_____ ID#_____

Group #_____ Telephone#_____

Emergency Contact

Name _____ Telephone # _____

Relationship_____

Employer Information

Name _____ Telephone # _____

Employer address _____ Occupation _____

Referred By _____

Telephone #_____

Primary Care Physician:_____

PAYMENT AUTHORIZATION

I authorize the release of any medical information necessary to process claims for medical services rendered, and also hereby authorize carrier to pay ABRAHAM (AVI) M. ISHAAYA M. D. a PROFESSIONAL CORPORATION directly for any benefits due to me. I understand and agree that regardless of my account for any professional services rendered.

Signature_____ Date _____

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Abraham Ishaaya MD, APC Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Relationship to Patient

_____ Time:_____AM/PM
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	

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