Patient Information Form
Part 1

Please print before filling in.
This is a confidential record and will be kept in your doctor's office and will not be released to anyone without your prior authorization.

Dr. Domingo E. Galliano Jr.
MD, FACS, FASCRS
University Surgical Associates
GALLIANOSURGERY.COM
18308 Murdock Circle, Suite 108
Port Charlotte, Florida 33948

VOICE - 941.625.3411
FAX - 941.625.1792

email: office@gallianosurgery.com

Date of Visit: ___/___/_____ Date of Last Physical Exam____/____/_____

Last Name: _____First Name _____ Middle Name _____

Social Security Number: _____ DOB ____/____/_____

Reason for your visit: _____

History of Present Illness

Location of the problem: _____

On a scale of 1-10, 10 as most severe, describe your problem: 1 2 3 4 5 6 7 8 9 10

When did you notice the problem: _____

Does anything help or make the problem worse? (sitting, standing, running, etc) _____

Is there anything else that occurs at the same time?_____

Is the problem constant or variable?_____

Does the problem interfere with your normal activities? Yes _____ No_____ Explain_____

How?_____

How long does the problem last? _____

LIST ANY PAST ILLNESSES AND LIST ANY PAST SURGERIES AND THE DATES THEY OCCURRED: DATES THEY OCCURRED:

Date	Disease	Please answer:	Yes	No	How often
		Do you smoke?			
		Do you drink?			
		Do you excercise?			

LIST ANY MEDICATIONS YOU ARE ON: PLEASE LIST ANY ALLERGIES YOU CURRENTLY HAVE

Medications	Allergies

LIST ALL SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY: (EXAMPLE DIABETES, CANCER, HEART DISEASE, ETC.)

Illness	Relationship of person diagnosed with disease

PHYSICIAN USE ONLY: (COMMENTS/NOTES)