

PATIENT HISTORY (ADULTS)

Hugh N. Hazenfield, M.D., F.A.C.S.

Name of Patient: _____

Today's Date: ___ / ___ / ___

Referred by: _____ His/Her Address: _____

Do you want us to send a report to your physician? Yes No

Why are you seeing Doctor Hazenfield today? _____

PAST HISTORY AND FAMILY HISTORY

Have you or a family member ever had the following (Check and explain all that apply):

<u>Patient</u>	<u>Family</u>	<u>Describe</u>	<u>Patient</u>	<u>Family</u>	<u>Describe</u>
Fever (at present)..... <input type="checkbox"/>		_____	Hepatitis or HIV <input type="checkbox"/>		_____
Weight Loss (recent)..... <input type="checkbox"/>		_____	Skin Abnormalities..... <input type="checkbox"/>		_____
Visual Problems/Glaucoma.... <input type="checkbox"/>		_____	Nerve Disorder or Stroke <input type="checkbox"/>		_____
Hearing Loss <input type="checkbox"/>		_____	Psychological Disorder..... <input type="checkbox"/>		_____
Frequent Ear Infections..... <input type="checkbox"/>		_____	Diabetes <input type="checkbox"/>		_____
Ringing or Noise in Ears <input type="checkbox"/>		_____	Thyroid Disorder..... <input type="checkbox"/>		_____
Other Ear Symptoms..... <input type="checkbox"/>		_____	Bleeding disorder..... <input type="checkbox"/>		_____
Ear Surgery <input type="checkbox"/>		_____	Easy Bruising..... <input type="checkbox"/>		_____
Hypertension <input type="checkbox"/>		_____	Enlarged Glands..... <input type="checkbox"/>		_____
Heart Disease <input type="checkbox"/>		_____	Drug Reaction or Allergy <input type="checkbox"/>		_____
Bronchitis/Short Breath <input type="checkbox"/>		_____	To what? _____		
Asthma <input type="checkbox"/>		_____	What occurred? _____		
Noisy Breathing..... <input type="checkbox"/>		_____	Allergies (other than drugs) <input type="checkbox"/>		_____
Ulcers or Heartburn <input type="checkbox"/>		_____	To what? _____		
Vomit Blood or Rectal Blood .. <input type="checkbox"/>		_____	Cancer <input type="checkbox"/>		_____
Urinary Tract Disease..... <input type="checkbox"/>		_____	Type of Cancer _____		
Urinary Retention ... <input type="checkbox"/>		_____	Anesthetic Problems..... <input type="checkbox"/>		_____
Venereal Disease... <input type="checkbox"/>		_____	What occurred? _____		

◆ Other health problems, including high cholesterol: _____

◆ Have you ever had surgery? Yes No If so, what and when? (Include tonsillectomy, appendectomy, etc.) _____

◆ Have you ever had a transfusion of blood or blood products? Yes No

If so, when and approximately how many? _____

◆ Do you smoke? Yes No What and how much? _____ How many years? _____

If you quit, when? _____ How much did you smoke? _____ How many years? _____

◆ Do you drink alcoholic beverages? Yes No

What, how much, and how frequently? _____

◆ Do you use or have you used recreational drugs, including marijuana? Yes No How frequently? _____ (If

you prefer not to answer, please discuss with Doctor Hazenfield.)

What medications (including aspirin) do you take?

Medication	Dose	Frequency	Medication	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If you use your voice professionally, please let the receptionist know.

THANK YOU!