

PATIENT HISTORY (PEDIATRIC)

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

Name of Patient: _____

Today's Date: ___ / ___ / ___

Referred by: _____ His/Her Address: _____

Do you wish that a report be sent to the referring physician? Yes No

Why is the patient seeing Dr. Hazenfield today? (Be specific) _____

PAST HISTORY AND FAMILY HISTORY

	<u>Patient</u>	<u>Family</u>	<u>Relationship</u>		<u>Patient</u>	<u>Family</u>	<u>Relationship</u>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug Reaction/Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	To what? _____			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	What occurred? _____			
Type of Cancer _____				Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	To what? _____			
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Noisy Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ear Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Tract Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anesthetic Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	What occurred? _____			
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other health problems: _____

Has the patient ever had surgery? Yes No If so, what and when? _____

Has the patient ever had a transfusion of blood or blood products? Yes No

If so, when and approximately how many? _____

Has the patient ever been hospitalized? Yes No When and what for? _____

Has the patient had any of the following: Measles Mumps Meningitis a very high fever?

Does the patient live with his/her mother father both?

How many of the patient's siblings live at home? _____ Ages: _____

Does anyone in the patient's home smoke? Yes No Who? _____

What medications (including aspirin) does the patient take?

Medication Dose Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

THANK YOU!