PETER T. HETZLER
MD, FACS

PATIENT MEDICAL RECORD

Date _____ /_____ /_____

Name: _____ DOB: ___/___/____ Age: _____ SSN: _____
Ht: _____ Wt: _____ Marital Status: _____ Sex: (M) (F) E-mail: _____
Home phone: (___)_____ Cell phone: (___)_____ Work phone: (___)_____
Street Address: _____ City: _____ State: _____ ZIP code: _____
P.O.Box: _____ Friend, family or referring physician: _____
Occupation: _____ Employer: _____ Please write the reason for visit below:
_____

DO YOU HAVE OR HAVE YOU HAD (If yes, please give date of occurrence)

- ☐ Accidents/Injury _____
- ☐ Anesthesia problems _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Autoimmune disorders _____
- ☐ Bladder infection _____
- ☐ Bleeding disorder _____
- ☐ Bleeding tendency _____
- ☐ Brain tumor _____
- ☐ Bronchitis _____
- ☐ Cancer – Breast _____
- ☐ Cancer – Skin _____
- ☐ Cancer – Ovarian _____
- ☐ Cancer – Prostate _____
- ☐ Cancer – Others _____
- ☐ Cardiac disease/attack _____
- ☐ Colitis/IBS _____
- ☐ Congenital heart _____
- ☐ Diabetes _____
- ☐ Eczema _____
- ☐ Endocrine disease _____
- ☐ Epilepsy _____
- ☐ Fever post op _____
- ☐ Hay fever _____
- ☐ Heart murmur _____
- ☐ Hepatitis _____
- ☐ High blood pressure _____
- ☐ Hives _____
- ☐ Kidney disease/stones _____
- ☐ Leukemia_____
- ☐ Liver disease _____
- ☐ Malignant hyperthermia _____
- ☐ Melanoma _____
- ☐ Migraines _____
- ☐ Pneumonia _____
- ☐ Psoriasis _____
- ☐ Radiation therapy _____
- ☐ Respiratory disease _____
- ☐ Rheumatic heart disease _____
- ☐ Rheumatoid arthritis _____
- ☐ Stroke _____
- ☐ Thyroid disorder/goiter _____
- ☐ Tonsillitis _____
- ☐ Tuberculosis _____
- ☐ Ulcers _____
- ☐ Other diseases _____
- _____
- _____

MEDICATIONS

Are you presently taking any of the following medications? (If yes, please give name and dosage)

- ☐ Antibiotics _____
- ☐ Arthritis medication _____
- ☐ Aspirin, Bufferin, Anacin _____
- ☐ Birth control _____
- ☐ Blood pressure pills _____
- ☐ Blood thinner med. _____
- ☐ Cortisone _____
- ☐ Digitalis _____
- ☐ Headache med. _____
- ☐ Hormones _____
- ☐ Insulin/diabetic med. _____
- ☐ Sleeping pills _____
- ☐ Thyroid medication _____
- ☐ Tranquilizers _____
- ☐ Water pills _____
- ☐ Other medications _____
- _____
- _____
- _____
- _____

PATIENT PAST SURGERIES/TREATMENTS (if none, please write none)

Surgery/Treatment	Date	Notes / Anesthesia Complications	Physician/Treating

ALLERGIES (if none, please write none)

Allergy	Reaction	Notes

DO YOU KNOW OF ANY **RELATIVE** WHO HAS OR HAD (If yes, please give relationship)

- ☐ Adopted
- ☐ Accidents/Injury _____
- ☐ Anesthesia problems _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Autoimmune disorders _____
- ☐ Bladder infection _____
- ☐ Bleeding disorder _____
- ☐ Bleeding tendency _____
- ☐ Brain tumor _____
- ☐ Bronchitis _____
- ☐ Cancer – Breast _____
- ☐ Cancer – Skin _____
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- ☐ Cancer – Prostate _____
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- ☐ Liver disease _____
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- ☐ Melanoma _____
- ☐ Migraines _____
- ☐ Pneumonia _____
- ☐ Psoriasis _____
- ☐ Radiation therapy _____
- ☐ Respiratory disease _____
- ☐ Rheumatic heart disease _____
- ☐ Rheumatoid arthritis _____
- ☐ Stroke _____
- ☐ Thyroid disorder/goiter _____
- ☐ Tonsillitis _____
- ☐ Tuberculosis _____
- ☐ Ulcers _____
- ☐ Other diseases _____

_____

WOMEN ONLY

	Yes	No	Details
Are you still having monthly menstrual periods?	☐	☐	*Date of last period:* _____
Are you currently pregnant or lactant?	☐	☐	_____
Have you ever been pregnant?	☐	☐	*If yes, please answer the following questions:*

How many times?	*How many cesarean op.?*	*Did you ever get hyperpigmentation or masking?*	*Have you ever breastfed?*
_____	_____	_____	_____

Have you ever had a miscarriage? If yes, please give dates	☐	☐	_____
Do you have heavy bleeding with your periods?	☐	☐	_____
Do you feel bloated and or irritable before your periods?	☐	☐	_____
Have you ever had a breast discharge? If yes, when?	☐	☐	_____
Have you ever had a mammogram? If yes, when was the last one?	☐	☐	_____

PATIENT ABILITY TO HEAL

	Yes	No	Details
Does your skin appear fragile, or sunburns easily?	☐	☐	_____
Do you form thick or raised scarring from a cut or burn?	☐	☐	_____
Do you ever get cold sores?	☐	☐	_____
Do you bruise easily?	☐	☐	_____
Do you take aspirin regularly? If yes, how often?	☐	☐	_____
Do you smoke? If yes, how often?	☐	☐	_____
Have you ever smoked? If yes, for how long?	☐	☐	_____
Do you drink alcoholic beverages? If yes, how often?	☐	☐	_____
Have you ever had a chest x-ray? If yes, when?	☐	☐	_____
Do you frequently have bleeding gums?	☐	☐	_____

IN CASE OF EMERGENCY

Name of emergency contact: _____ Relationship to patient: _____

Address: ☐ Same as patient | Other: _____

Home phone: (___)_____ Cell phone: (___)_____ Work phone: (___)_____

MEDICAL HISTORY VERIFICATION

All information provided above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Peter T. Hetzler MD FACS or insurance company to release any information required to process my claims.

Patient printed name: _____Patient Signature: _____

Parent/Guardian printed name: _____ Parent/Guardian Signature: _____