John Fewins, M.D.

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Full Name _____ Appointment Date _____

Male ☐ Female☐ Date of Birth _____ HT:_____WT:_____

Pharmacy Preference (include location)_____

Name of Primary Care Physician _____ Name of Referring Physician_____

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ No ☐ Yes If yes, please list below *include dosages*.

Medication Name	Dosage	How often taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ No ☐ Yes If yes, please list below.

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have had problems with anesthesia (being numbed or put to sleep)? ☐ No ☐ Yes

Have had any ear nose or throat surgery? ☐ No ☐ Yes (type and date)_____
_____
_____

Have had any other surgeries? ☐ No ☐ Yes
(type and date)_____
_____

Have you ever been hospitalized for non-surgical reasons? ☐ No ☐ Yes If so please explain
_____