John F. Carew MD, PC

PATIENT QUESTIONNAIRE

Name	Occupation	
In your own words describe what brings you to the doctor:	Height	Weight
	Allergies to Medications	

Please list all medical problems you have had in the past:	Please list all operations you have had in the past:	
	Operation	Date

Please list all medications you currently take:	Do you have any of the following symptoms:	Yes	No
	Weight loss		
	Vision problems		
	Ear pain		
	Nose bleeds		
	Cough		

	Yes	No	Chest Pain		
Do you smoke or have you ever smoked regularly			Headaches		
Do you drink alcohol regularly			Rash		
Do you have a family history of cancer			Depression		
			Leg weakness		