## W.C.MAJOR, M.D. MEDICAL INFORMATION FORM

DATE_____ FAMILY DOCTOR_____

PATIENT NAME_____AGE_____DATE OF BIRTH_____

PHARMACY - NAME AND CITY _____

WHY ARE YOU HERE TODAY?_____

HAVE YOU HAD RECENT LABS ( ) OR X-RAYS ( )? _____ WHEN & WHERE_____

HAVE YOU HAD A COLONOSCOPY? _____ WHEN_____

HAVE YOU FALLEN IN THE LAST 3 MONTHS?_____

HAVE YOU HAD A FLU SHOT? _____DATE_____

**REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY**

CONSTITUTIONAL SYMPTOMS (FEVER, WEIGHT LOSS) _____

EYES ,EARS ,NOSE, MOUTH,THROAT:_____

CARDIOVASCULAR (STROKE, SEIZURES, HEART ATTACK HIGH BLOOD PRESSURE, POOR CIRCULATION):_____

_____

RESPIRATORY (LUNGS) (PNEUMONIA, EMPHYSEMA):_____

GASTROINTESTINAL (STOMACH, BOWEL HABITS, BLEEDING):_____

GENITOURINARY (KIDNEY STONES/INFECTIONS, PROSTATE, PELVIC PROBLEMS):_____

MUSCULOSKELETAL (MUSCLE/BONE/ARTHRITIS):_____

SKIN PROBLEMS( POST OPERATIVE WOUND INFECTION, MRSA INFECTION, SKIN CANCER, SPIDER BITE): _____

_____

NEUROLOGICAL (NERVOUS):_____

PSYCHIATRIC / DEPRESSION:_____

ENDOCRINE (DIABETES/HORMONES/THYROID):_____

HEMATOLOGIC (BLOOD) LYMPHATIC (LYMPH NODES):_____

**SURGICAL PROCEDURES AND DATES :**_____

_____

**MEDICAL ADMISSIONS TO HOSPITAL AND DATES:**_____

**MEDICATIONS: DOSAGE AND FREQUENCY:**_____

_____

**NON-PRESCRIPTION MEDICINES**:_____

ARE YOU ON A WEIGHT LOSS PROGRAM THAT REQUIRES MEDICATIONS OR DIETARY SUPPLEMENTS?_____

IF YES, PLEASE EXPLAIN._____

**ALLERGIES (TO MEDICINE) AND SEVERITY:**_____

**FAMILY MEDICAL HISTORY PLEASE LIST ANY CANCER ( BREAST, LUNG, COLON, ETC.) DIABETES, HEART DISEASE**

GRANDPARENTS:_____

FATHER:_____

MOTHER:_____

CHILDREN:_____

SISTERS/BROTHERS:_____

**PERSONAL HISTORY**

MARITAL STATUS: _____

TOBACCO USE: NO_____ YES____ #DAY____X____YEARS **PATIENT SIGNATURE**_____

ALCOHOL USE: NO_____ YES_____ **DATE**_____

**PHYSICIAN SIGNATURE**_____DATE:_____