GENESIS ORTHOPEDICS & SPORTS MEDICINE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Preferred Language: _____

PHARMACY PREFERENCE

Local Pharmacy Name: _____ Town: _____ Street: _____

PATIENT'S MEDICAL HISTORY (yes or no)

	Y	N		Y	N		Y	N		Y	N
Alcohol/Drug Abuse			Cataract			Heart Attack			Nerve/Muscle Disease		
Allergies (other than meds)			Circulation Problems			Heartburn/GERD/Ulcers			Osteoporosis		
Anemia			Colitis/Bowel Disease			High Blood Pressure			Pneumonia		
Anxiety			Congestive Heart Failure			HIV/AIDS			Seizures		
Arthritis			Chronic Obstructive Pulmonary Disease			Jaundice			Sickle Cell		
Asthma			Depression			Kidney Disease			Stroke		
Birth Defect/Genetic Problem			Diabetes			Meningitis			Thyroid Disease		
Blood Clots			Emphysema			Mental Health Problems			Tuberculosis		
Blood Transfusion			Glaucoma			Murmur			Viral Hepatitis		
Cancer			High Cholesterol			ADD/ADHD			Foot Problems?		
Other Medical History:											

PATIENT'S SURGICAL HISTORY (yes or no)

	Y	N		Y	N		Y	N		Y	N
Abdomen Surgery			Brain Surgery			C-Section			Hernia Repair		
Appendectomy			Breast Surgery			Cholecystectomy (Gallbladder)			Hysterectomy		
Surgical Repair: Broken Bones/Fractures			Colon Surgery			Adnoid/Tonsillectomy			Joint Replacement		
Coronary Artery Bypass Graft			Cosmetic Surgery			Sterilization			Ear Tubes		
Other Surgical History:											

PATIENT's SOCIAL HISTORY for 1O YRS OLD and UP

Tobacco Use	Yes	NEVER		Quit		Passive	Comment_____
Packs/Day	.25	.5	1	1.5	2	3	Years of Smoking _____
Quit Date							

Alcohol Use	Y	N		
Drinks/Week			Glass(es) of Wine	Comment_____
			Can(s) of Beer	
			Shot(s) of Liquor	
			Drinks containing O.5 oz of alcohol	

Internal Drug Use	Y	N		Comment_____	
Per Week				Types	Marijuana / Methamphetamines / Cocaine / IV

OVER →

Please complete the form below relating to your family's medical history.

PLACE AN "X" IN THE APPROPRIATE BOX BELOW (see example)

PATIENT'S FAMILY HISTORY

Relationship		Name	Deceased	Cancer: Type and age of death (if applicable)	Diabetes-Type	Heart Failure	Hypertension (High Blood Pressure)	Asthma	High Cholesterol	Arthritis-Rheumatoid	Arthritis-Osteo	Stroke	Thyroid Disease	Seizures	Migraines	Rashes/Skin Problems	Other _____
Example	**Sister**	**Sally**			X			X				X					
Parents	Mother																
Parents	Father																
Siblings																	
Siblings																	
Siblings																	
Siblings																	
Siblings																	
Children																	
Children																	
Children																	
Children																	
Grandparents	[1]MGM																
Grandparents	[1]MGF																
Grandparents	[2]PGM																
Grandparents	[2]PGF																

1: Maternal
2: Paternal

Current Medications: _____

_____

Allergies: _____

_____

Do you see other physicians? Yes No

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____