GENESYS Family Medicine, PC

Patient Name: _____ **DOB**: _____

List any **ALLERGIES** to drugs, latex, etc.:

List any **MEDICATIONS AND/OR HERBAL SUPPLEMENTS OR VITAMINS** you take on a regular basis: Please include **STRENGTH AND DOSING INSTRUCTIONS.**

FAMILY HISTORY of any of the following:

High Blood pressure	Father____Mother____Sibling____	Asthma/Lung Disease	Father____Mother____Sibling____
Heart Disease	Father____Mother____Sibling____	Epilepsy/Convulsions	Father____Mother____Sibling____
High Cholesterol	Father____Mother____Sibling____	Bleeding disorder	Father____Mother____Sibling____
Stroke	Father____Mother____Sibling____	Kidney Disease	Father____Mother____Sibling____
Cancer	Father____Mother____Sibling____	Mental Illness	Father____Mother____Sibling____
Diabetes	Father____Mother____Sibling____	Alcoholism	Father____Mother____Sibling____
Thyroid Disease	Father____Mother____Sibling____	Other:_____	Father____Mother____Sibling____

SOCIAL HISTORY

Do you drink caffeine? (Yes /NO) How much: Coffee _____ Tea ____ Colas_____ Energy Drinks_____
Do you drink Alcohol? Liquor_____ Beer_____ Wine_____ How often? Daily Weekly Socially
Current Smoker: (Yes /NO) Number of Years_____ Packs per day_____
Former Smoker: (Yes /NO) Number of Years_____ Packs per day_____ Age Stopped_____
Exposure to Secondhand Smoke: (Yes /NO)
Have you used recreational drugs recently? If yes, which ones? _____

ADDITIONAL MEDICAL INFORMATION:

Date of last: Flu Vaccine _____ Pneumococcal Vaccine _____ COVID 19 Vaccine _____
Tetanus vaccine_____ Colonoscopy_____ Pap smear_____ Mammogram_____
Bone Density_____ PSA (Prostate Screening) _____
PLEASE BRING CURRENT IMMUNIZATION RECORDS FOR ALL PATIENTS 18 YO AND UNDER
Do you have any specific communication requirements due to hearing, vision or cognitive issues: (YES / NO)
List any: _____
Please list any other physicians and their specialty who are currently treating you:
_____

ALL SURGERIES

Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

HOSPITALIZATIONS:

Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____
Date: _____ Reason: _____

PLEASE DESCRIBE YOUR CURRENT MEDICAL CONDITION: _____
_____