Genesis ORTHOPEDIC
SINCE 1989

PATIENT INFORMATION

Patient's Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Gender ☐ M ☐ F MRN _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SS# _____ Email _____

Maiden Name _____ Mother's First Name _____ Father's First Name _____

Race _____ Ethnicity _____ Marital status ☐ Single ☐ Married

Employer Name _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

SPOUSE'S INFORMATION

Spouse's Last Name _____ First _____ Middle Initial _____

Date of Birth _____ Gender ☐ M ☐ F

Home Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SS# _____ Email _____

Maiden Name _____ Mother's First Name _____ Father's First Name _____

Race _____ Ethnicity _____ Marital status ☐ Single ☐ Married

Employer Name _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

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Name _____

MRN _____ Date of Birth _____

INSURANCE

Primary Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Date of Birth _____

Patient's Relationship to Policy Holder _____ Group # _____ ID # _____

Employer of Policy Holder _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance Company _____ Phone _____

Insurance Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Date of Birth _____

Patient's Relationship to Policy Holder _____ Group # _____ ID # _____

Employer of Policy Holder _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

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INTAKE FORM

Today's date _____ Name _____

MRN _____ Date of Birth _____

Preferred language _____ Age _____ Gender ☐ M ☐ F Height _____ Weight _____

Referring Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Care Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Pharmacy of Choice _____ Phone _____

Address _____ City _____ State _____ Zip _____

What is the reason for your visit today? _____

Location of pain (include side) _____ Are you right or left hand dominant? ☐ R ☐ L

How long have you had this pain? _____ Kind of pain: ☐ Dull ☐ Sharp ☐ Tingling ☐ Other

When does the pain occur? ☐ At rest ☐ With activity ☐ At night ☐ Other

List any other symptoms associated with current problem? _____

How severe is the pain? *(very little pain)* **1 2 3 4 5 6 7 8 9 10** *(excruciating/I can't function)*

What makes it feel better? ☐ Pain medicine ☐ Ice ☐ Heat ☐ Rest ☐ Elevation ☐ Other

What brought on the pain? _____

If the result of an injury, date occurred _____ Is is better? ☐ Y ☐ N It is worse? ☐ Y ☐ N

MEDICAL HISTORY

Please list all past medical conditions, whether they relate to your current condition or not.

Asthma	☐ Y	☐ N	DVT/PE (Blood clot)	☐ Y	☐ N
Blood/plasma transfusion	☐ Y	☐ N	Heart disease	☐ Y	☐ N
Cancer	☐ Y	☐ N	Lung disorder	☐ Y	☐ N
Cholesterol	☐ Y	☐ N	Stomach/intestinal disorder	☐ Y	☐ N
Clotting disorder	☐ Y	☐ N	Thyroid problems	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Other _____		
Hypertension	☐ Y	☐ N	Other _____		

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ALLERGIES

List anything you are allergic to, including medications, environmental agents, food, etc.

☐ No allergies

Allergic to:	Reaction	Allergic to:	Reaction

SURGICAL HISTORY

Have you ever had general anesthesia? ☐ Y ☐ N

Have you had any problems with anesthesia? ☐ Y ☐ N If yes, what? _____

List below all surgeries you have had.

Surgery/Procedure	Approx. Date	Physician/Surgeon	Complications, if any

MEDICATIONS

List anything you are taking, including prescriptions, over-the-counter medications, and herbal/vitamin supplements.

Name	Prescribed by	For what condition?	Dose	Frequency

FAMILY HISTORY

Please indicate any major illnesses or health conditions for family members.

	Alive	Age	Health Problems	Deceased	Cause of Death
Mother	☐			☐	
Father	☐			☐	

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MRN _____ Date of Birth _____

SOCIAL HISTORY

Occupation _____ Marital status ☐ Single ☐ Married ☐ Other

Home: ☐ 1 story ☐ 2 story (# of stairs: _____) ☐ Apartment (Elevator ☐ Y ☐ N) ☐ Motor/RV

How often do you exercise? _____ times per week School sports _____

Tobacco use: ☐ None ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco

Average/day: _____ # of years: _____ If not currently, have you previously? ☐ Y ☐ N

Alcohol use: Average per week: _____ If not currently, have you previously? ☐ Y ☐ N

Marijuana use: ☐ Y ☐ N Do you have a medical marijuana card? ☐ Y ☐ N

REVIEW OF SYSTEMS

Constitutional ☐ None ☐ Fatigue ☐ Headache ☐ Weakness ☐ Recent weight change

Eyes ☐ None ☐ Glasses ☐ Surgery _____
☐ Blurred vision ☐ Cataracts ☐ Floaters

Ears, Nose, Throat ☐ None ☐ Congestion ☐ Hearing loss ☐ Sinus pain ☐ Tinitus ☐ Dentures

Lungs/Breathing ☐ None ☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Hoarseness ☐ COPD
☐ CPAI ☐ Oxygen

Heart ☐ None ☐ Murmurs ☐ Irregular heartbeat ☐ Pacemaker ☐ Stent ☐ Surgery

Gastrointestinal ☐ None ☐ Nausea ☐ Vomiting ☐ Surgery _____
☐ Stomach aches ☐ Constipation ☐ Diarrhea ☐ GERD ☐ Diverticulitis

Bladder ☐ None ☐ Incontinence ☐ Frequency ☐ Pain ☐ Difficulty urinating ☐ History of UTI

Endocrine ☐ None ☐ Diabetes ☐ Thyroid problems ☐ Delays in growth ☐ Growth problems

Musculoskeletal ☐ None ☐ Joint pain (location _____) ☐ Broken bones (location _____)

Bleeding ☐ None ☐ Anemia ☐ Easy bleeding ☐ Easy bruising ☐ History of DVT

Neurological ☐ None ☐ Dizziness ☐ Numbness/tingling (location _____) ☐ Tremors
☐ Frequent falls ☐ Seizures (date of last seizure _____)

Integumentary ☐ None ☐ Rashes ☐ Skin cancer (location _____)
☐ Skin disorders ☐ Connective tissue disorders

Psychiatric ☐ None ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Trouble sleeping ☐ Bipolar

Immunologic ☐ None ☐ Asthma ☐ Hay fever ☐ Chronic rashes ☐ Communicable diseases

☐ Other _____

_____ _____
Signature (person completing form) Date

_____ _____
Physician signature Date