Additional Patient Information From:

Name:_____ Date:_____

Are you currently taking any medications? (Please circle one) Yes No

If yes, please list

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? (Please circle one) Yes No

If yes, please list

_____ _____ _____

_____ _____ _____

What is your race? (Please circle one)

White Black or African American Native Hawaiian or Other Pacific Islander

Asian American Indian or Alaska Native Other Race More Than One Race

What is your ethnicity? (Please circle one)

Hispanic or Latino Not Hispanic or Latino

What is your preferred language? (Please circle one)

English Spanish French German Italian Russian

Portuguese Chinese Japanese Korean Vietnamese

What is your smoking status? (Please circle one)

Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker

What is your preferred method of communication for private health data? (Please circle one)

Home Phone Work Phone Mobile Phone E-Mail Standard Mail

OFFICE USE ONLY:

Wt:_____ Ht:_____ Blood Pressure:_____/_____ Pulse: _____ Date:_____