

Date: ____/____/____

Name: _____ Patient ID Number: _____ Date of Birth ____/____/____

Please fill out this section completely

What is your preferred Language?

- | | | | |
|----------------------------------|-------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> French | <input type="checkbox"/> German | <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean | <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Declined | <input type="checkbox"/> _____ |

Gender

- Male
 Female

Ethnicity

- Hispanic or Latino Not Hispanic or Latino Declined

Race

- | | | |
|--|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Black, African American | <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> American Indian, Alaska Native | <input type="checkbox"/> Other | <input type="checkbox"/> Declined |
| <input type="checkbox"/> Native Hawaiian, Pacific Islander | | |

Smoking Status

- | | | |
|---|---|---|
| <input type="checkbox"/> Current every day smoker | <input type="checkbox"/> Current some day smoker | <input type="checkbox"/> Former Smoker |
| <input type="checkbox"/> Never Smoked | <input type="checkbox"/> Smoker, current status unknown | <input type="checkbox"/> Unknown, if ever |

Medications I currently do not take any medications

_____ Dosage: _____	_____ Dosage: _____
_____ Dosage: _____	_____ Dosage: _____
_____ Dosage: _____	_____ Dosage: _____
_____ Dosage: _____	_____ Dosage: _____
_____ Dosage: _____	_____ Dosage: _____

Medication Allergies: _____

Patient Signature: _____ Date: _____

This section to be completed by the doctor

Height _____ in Weight _____ lbs Blood Pressure ____/____ mmHg Right Arm / Left Arm
Pulse _____ bpm Respirations _____ rpm Temperature _____

Dr. Signature: _____ Date: _____