PATIENT NAME:_____DATE:_____

Additional Patient Information Form

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

If yes, please list PLEASE INCLUDE DOSE AND HOW OFTEN TAKEN:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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 Asian American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander 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?

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

B/P_____PULSE_____DATE:_____

HEIGHT:_____WEIGHT:_____