Update Health Information

General Information

First Name _____
Middle Initial _____
Last Name _____

Race (circle only 1) American Indian, Alaska Native, Asian, White, Black or African American, Native Hawaiian, Other Pacific Islander, Declined to State

Ethnicity (circle only 1) Declined to State, Hispanic or Latino, Not Hispanic or Latino

Preferred Language _____
Email Address _____

For Office Use Only
Account Number _____
Patient Height _____
Patient Weight _____
Patient BMI _____
Patient Blood Pressure _____

Smoking Status (circle only 1) Current Every Day Smoker, Current Some Day Smoker, Former Smoker, Never Smoker

Smoking Start Date: _____ End Date: _____

In an effort to quit smoking, I am currently taking: _____

Do you have any allergies to medication? Yes No
If Yes, please indicate the following:

Allergy: _____ Allergy: _____

Allergy: _____ Allergy: _____

Are you currently taking any medication ? Yes No
If Yes, please indicate the following:

Medication: _____ Medication: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____

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