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: ______________________________
Reaction: ______________________________
Start Date: ______________________________
End Date: ______________________________

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End Date: ______________________________

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End Date: ______________________________

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Reaction: ______________________________
Start Date: ______________________________
End Date: ______________________________

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

Medication: ____________________________
Route: Oral
Intravenous
Other: ____________________
Frequency: ______________________________
Began Use: ______________________________
Discontinued Use: _________________________

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