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

Account Number ______________________
Patient Height _________________________
Patient Weight __________________
Patient BMI __________________
Patient Blood Pressure __________________
Age _____________

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

Preferred Language ____
Email Address ____

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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Reaction: ______________________________
Start Date: _____________________________
End Date: ______________________________

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Reaction: ______________________________
Start Date: _____________________________
End Date: ______________________________

Allergy: _______________________________
Reaction: ______________________________
Start Date: _____________________________
End Date: ______________________________

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

Medication: _____________________________
Frequency: ______________________________
Began Use: ______________________________
Discontinued Use: _________________________

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Frequency: ______________________________
Began Use: ______________________________
Discontinued Use: _________________________

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Frequency: ______________________________
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Discontinued Use: _________________________

Please list any family health history items we should be aware of:

Condition: ______________________________ Relationship: ______________________________
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Condition: ______________________________ Relationship: ______________________________