Date:_____

Patient Supplemental Data – Updates

(please print)

1. Patient Name: _____

Last *First* *Middle Initial*

2. Ethnicity: ☐Hispanic ☐Not Hispanic

Race: ☐White/Caucasian ☐Black/African American ☐American Indian/Alaska Native

☐Asian ☐Native Hawaiian/Pacific Islander ☐Other:_____

3. Preferred Language: ☐English ☐Spanish ☐Hmong ☐Lao ☐Other: _____

4. Preferred Method of Communication:

☐Home ☐Phone ☐Work Phone ☐Mobile Phone ☐Standard Mail ☐e-Mail

5. Smoking Status: *(Individuals age 13 years and older)*:

☐Current Every Day Smoker ☐Former Smoker

☐Current Some Day Smoker ☐Never Smoker

6. Medication Allergies: ☐None -or- ☐See List Below

_____ _____ _____ _____

_____ _____ _____ _____

7. Current Prescription Medications: ☐None ☐See List Below ☐See Attached List

(You may bring a list of all your medications and dosage to your next visit)

Name of Prescription	Dosage (e.g. 10 mg)	Form (Tab, capsules, etc.)	Frequency (#times per day,week,as needed)

Clinic Use ONLY: Vitals (age 2 yrs+)

Height: _____ inches; Weight: _____ lbs; Pulse: _____

Blood Pressure: (Left Arm/Right Arm) _____/_____ (Sitting/Standing/Supine)

Staff Initials _____