

As part of the American Recovery and Reinvestment Act (ARRA), the Federal Electronic Medical Records Mandate requires that we gather the following information.

Name \_\_\_\_\_

Date \_\_\_\_\_

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

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

- Preferred Language \_\_\_\_\_

- Smoking status (circle only 1) Current Every Day Smoker  
Current Some Day Smoker  
Former Smoker  
Never Smoker  
In an effort to quit smoking, I am currently taking: \_\_\_\_\_

**For Office Use Only**

Account Number \_\_\_\_\_

Patient Height \_\_\_\_\_

Patient Weight \_\_\_\_\_

Patient BMI \_\_\_\_\_

Patient Blood Pressure \_\_\_\_\_

Do you have any allergies to **medication**? Yes No

If Yes, please list the name of the medication:

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Are you currently taking any **prescription medication**? Yes No

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Medication: \_\_\_\_\_

Is there a family history of?

If YES, please indicate (M) Mother (F) Father (S) Sister (B) Brother (only)

Arthritis: \_\_\_\_\_

Cancer: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Other: \_\_\_\_\_

None: \_\_\_\_\_