FIRST Name_____ MIDDLE Name_____ LAST Name_____

Nickname_____ Best Phone # for Contact_____ Birth date_____

Answer ALL 3 questions *This is used by Govt Agencies to evaluate Healthcare Disparities Nationally*

1. **Your ETHNICITY**: Hispanic Non-Hispanic Decline *2.* **Your Language: _____**

3. **Your RACE:** White Black Asian American Indian Pacific Islander

Marital Status: Single Married Committed Relationship Engaged Needs Work Happy Separated Divorced Widow

List all Doctors seen in the past 2 years: _____

Which Pharmacy do you use? _____ Location _____ Phone_____

PLEASE DO NOT LEAVE ANY BLANKS. CIRCLE THE BEST ANSWER OR PUT N/A, Question Mark OR DASH

We aren't just being nosey – Most questions are required by ins. This info is available to medical staff here & to your insurance co. IF they review your chart.

Highest Level of School: Student Grade _____ Finished Grade _____ 2 yr College 4 yr College Degree: _____

I work: Full Time Part Time Job Hunter Unemployed Retired Disabled Stay at home Mom I don't work

What work do you do? _____ **Do you like it?** Yes No Sometimes

Tobacco	Yes No Yr. Quit:	¼ ½ ¾ 1 pk More Daily	Since Age:	Want to QUIT? Using E-CIG?
Alcohol	Yes No Past	Beer Wine Liquor #_____per day #_____per wk Is it a problem?		
Caffeine	Yes No Past	**I get HEADACHES:** Never Daily Weekly Monthly **What Helps?** _____		
Marijuana	Yes No Past	**I wear GLASSES/CONTACTS:** Yes No For Reading For Driving **ARE YOU**: Righty Lefty		
Illegal Drug Use	Yes No Past	**I have HEARING LOSS:** No Right Left Both **I HAVE HEARING AIDS:** Yes No		
Addiction	Yes No Past	**I have FIREARMS:** No Yes In Lock Box Loaded Unloaded		
Verbal Abuse	Yes No Past	**SMOKE/FIRE ALARMS:** Got It Need to Get It **SEAT BELTS**: Never Sometimes Always		
Physical Abuse	Yes No Past	**I enjoy FAST FOOD:** NEVER RARELY YES _____x wk _____x mth		

When was your last: (Write N/A if never)

EYE EXAM _____

COLONSCOPY_____

ANNUAL HEALTH EXAM _____

BONE DENSITY _____

My SLEEP is: ENOUGH NOT ENOUGH TROUBLED #_____HRS/NIGHT

I am DEPRESSED: FREQUENTLY USUALLY SOMETIMES NEVER

My ENERGY LEVEL: GREAT GOOD NEED MORE WHAT ENERGY?

EXERCISE: DON'T ASK YES _____x wk _____x mth TYPE: _____

››› I TAKE MY MEDS: NO MEDS ALL THE TIME USUALLY SOMETIMES WHEN I CAN AFFORD IT

MEDICINE I TAKE (include over the counter & vitamins)		**HOSPITALIZATIONS/PROCEDURES & YEAR**

DRUG ALLERGIES: None or _____ **MY NORMAL WEIGHT** _____ LBS.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

The information on the Patient Health History Form is correct to the best of my knowledge. I will inform the staff of any changes.

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