Patient Protection Care Act Information

General Information

First Name _____ Date_____
Middle Initial _____ Acct#_____
Last Name _____ DOB _____

Race (please only circle one): American Indian Alaska Native
Asian Caucasian
African American Other Pacific Islander
Native Hawaiian Decline to State

Ethnicity (please only circle one): Decline to State Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____

Email Address: _____

Height: _____ Weight: _____

Do you have any history in your **immediate family** of health disease?
(I.e. cancer, high blood pressure, diabetes, high cholesterol, or heart disease)
If yes, please indicate **who and the health disease**:_____
_____

Smoking Status (please only circle one): Current Every Day Smoker
Current Some Day Smoker
Former Smoker
Never Smoked
Decline to State
In an effort to quit smoking, I am currently taking:_____

Do you have any allergies to medication? Yes No
If yes, please indicate: _____
_____

Are you currently taking any medication: Yes No
If yes, please indicate: _____
_____
_____
_____

----------*Office Use Only*----------

*Blood Pressure:*_____ *Pulse:*_____