Patient Name _____ **Date**_____

Patient Title: *(check one)* ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. ❑Prof. ❑Rev.

email address_____
By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method *(check one)*
❑Primary Phone ❑Secondary Phone ❑Mobile Phone ❑Home Email ❑Work Email

Employment Status *(check one)*
❑Employed ❑FT Student ❑PT Student ❑Other ❑Retired ❑Self Employed

Race *(check one)*
❑White ❑Black/African American ❑Hispanic ❑American Indian/Alaskan Native
❑Asian ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese
❑Native Hawaiian or other Pacific Island ❑Samoan ❑Guamanian or Chamorro ❑Other ❑I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑Unknown

Ethnicity *(check one)* ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I choose not to specify

Preferred Language *(check one)*
❑English ❑Spanish ❑American Sign Language ❑Chinese ❑French ❑German
❑Tagalog ❑Vietnamese ❑Italian ❑Korean ❑Russian ❑Polish
❑Arabic ❑Portuguese ❑Japanese ❑French Creole ❑Greek ❑Hindi
❑Persian ❑Urdu ❑Gujarati ❑Armenian ❑I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*
❑What is the name of your favorite pet? ❑In what city were you born? ❑What high school did you attend?
❑What is your favorite movie? ❑What is your mother's maiden name? ❑On what street did you grow up?
❑What was the make of your first car? ❑When is your anniversary?

Verification Answer to the Chosen question:_____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑Yes ❑Former smoker ❑Never been a smoker
If yes, how often do you smoke: ❑Current every day smoker ❑Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10
No interest *Very Interested*

Do you have diabetes? ❑Yes ❑No

Do you have high blood pressure? ❑Yes ❑No

To be performed by clinic staff:

Height: _____inches **Weight:**_____ lbs **BP:**___/____