Health Information Update

Name____

Address______________________________ **City** ___________________ **State**____ **Zip**________

Home Phone ____________________________ **Cell Phone** ______________________________

Email Address____

Your reason for this visit ____

Race
- ☐ American Indian
- ☐ Alaska Native
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Other Pacific Islander
- ☐ Native Hawaiian
- ☐ Declined to State

Ethnicity ☐ Declined to State ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Language ____

Smoking Status
- ☐ Current Smoker How much? ____________________________________
- ☐ Former Smoker
- ☐ Never Smoked

Family History	Cancer	Diabetes	Back Pain	Other
Mother	☐	☐	☐	☐____________________________
Father	☐	☐	☐	☐____________________________
Sibling	☐	☐	☐	☐____________________________

Are you currently taking any medication? **Yes** **No**
If **Yes**, please indicate the following:

Medication: ______________________________ Medication: ______________________________
Frequency: ______________________________ Frequency: ______________________________

Medication: ______________________________ Medication: ______________________________
Frequency: ______________________________ Frequency: ______________________________

Do you have any allergies to medication? **Yes** **No**
If **Yes**, please indicate the following:

Allergy: ______________________________ Allergy: ______________________________
Reaction: ______________________________ Reaction: ______________________________

Allergy: ______________________________ Allergy: ______________________________
Reaction: ______________________________ Reaction: ______________________________

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Print Name **Signature of Patient** **Date**