ELECTRONIC HEALTH RECORDS INTAKE FORM

First Name:_____Last Name:_____

Email address:_____

Preferred method of communication for patient reminders: (circle one) Email/ Phone/ Mail

DOB:____/____/____ Gender (Circle one) Male / Female Preferred language:_____

Smoking status (Circle one): Every day smoker/ Occasional Smoker/ Former Smoker/ Never Smoked

Height:_____Weight:_____Blood Pressure:_____/_____

Have you had a Flu Shot (Circle One) YES/NO If yes, when:_____

Race: American Indian or Alaska Native / Asian / Black or African American/ White Caucasian
Native Hawaiian or Pacific Islander / Other / I decline to answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino/ I decline to answer

Are you taking any medications? (Please include regularly used over the counter medications. If you have a list we can attach a copy.

Medication Name: **For what condition?**

Do you have any medication allergies? If yes list below. What is your reaction to the medicine?

Medication Name:

Patient Signature:_____Date:_____