

ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirement for the government EHR

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: _____

CMS requires providers to report both race and ethnicity

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: _____