UPDATE HEALTH INFORMATION

		DATE
GENERAL INFORMATION		FOR OFFICE USE ONLY
FIRST NAME		Account Number -
MIDDLE INITIAL		Patient Height "
LAST NAME		Patient Weight Ibs
SUFFIX		Patient BMI
CALLED NAME		Patient Blood Pressure /
RACE (MARK ONLY 1)	O American Indian	O Alaska Native
. ,	O Asian	O White
	O Black/African American	O Other Pacific Islander
	O Native Hawaiian	
	O Declined to state	
ETHNICITY (MARK ONLY 1)	O Not Hispanic or Latino	O Hispanic or Latino
,	O Declined to state	
PREFERRED LANGUAGE		
EMAIL ADDRESS		
	0	0
HABITS	O Current Everyday Smoker	O Current Some Days Smoker
	O Former Smoker	O Never Smoker
FAMILY HISTORY	NONE DIABETES CANCER	HEART ARTHRITIS BACK PAIN OTHER
MOTHER	· · · · ·	
FATHER BROTHER	· · · · ·	
SISTER	· · · · ·	
EXERCISE	O None O Moderate O Dail	W.
EXERCISE	O None O Moderate O Dail	
Are you currently taking any n	new medications(s) since your last v	visit? Yes O No O N/A 1st Visit O
	new medications(s) since your last v	
Are you currently taking any n	new medications(s) since your last v owing:	
Are you currently taking any n If Yes, please indicate the follo Frequency: Medication:	new medications(s) since your last v pwing:	visit? Yes O No O N/A 1st Visit O Frequency: Medication:
Are you currently taking any n If Yes, please indicate the follo Frequency: Medication:	new medications(s) since your last v pwing:	visit? Yes O No O N/A 1st Visit O Frequency:
Are you currently taking any n If Yes, please indicate the follo Frequency: Medication:	new medications(s) since your last v pwing: 0 Oral 0 Intravenous	visit? Yes O No O N/A 1st Visit O Frequency: Medication: Route: O Oral O Intravenous
Are you currently taking any n If Yes, please indicate the follo Frequency: Medication:	new medications(s) since your last v pwing: O Oral	visit? Yes O No O N/A 1st Visit O Frequency: Medication: Route: O Oral
Are you currently taking any n If Yes, please indicate the follo Frequency: Medication: Route:	ew medications(s) since your last v owing: O Oral O Intravenous O Other	visit? Yes O No O N/A 1st Visit O Frequency: Medication: Route: O Oral O Intravenous
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