Patient Name: _____ Date: _____

1. Current Medications

Name of Drug	Strength

2. Drug Allergies

Medication	Severity	Reaction
	Mild, Moderate, Severe	
	Mild, Moderate, Severe	
	Mild, Moderate, Severe	
	Mild, Moderate, Severe	

3. Smoking Status: **Circle One**

Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoked

4. Height _____ Weight _____

5. Preferred Language: **Circle One** ☐ English ☐ Spanish Other _____

6. Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Caucasian ☐ Hispanic or Latino

☐ Native Hawaiian or Pacific Islander ☐ Multi-Racial ☐ Other

Doctor's Use Only BP _____/_____