□ Completed □ DX_____ File # _____

EHR History & Examination

PRINT Patient Name_____ Date _____

DOB: _____/_____/_____ Phone #_____-_____-_____

EMAIL: _____

INITIAL _____ *I hereby acknowledge to being informed that my medical health records are available to me via a secure web based portal and that I will receive a password from Practice Fusion, if I should ever care to access my information.*

1. Demographics (Please mark A, B, and C)

			Don't know/ prefer not to say
A. Ethnicity	□ non-Hispanic	□ Hispanic	□
B. Preferred language	□ English □ other _____	□ Spanish	□
C. Race	□ white/Caucasian □ native American □ other _____	□ African American □ Hawaiian/Pacific Isl	□

***2.* Are you taking any medications?**

□ ***YES** ***If YES, please list any medications (be specific) you are currently taking along with dosage.** ***If you have a med list, we can copy it for you instead.***

_____ _____

_____ _____

_____ _____

□ **NO**

***3.* Are you allergic to any Medications?**

□ ***YES** ***If YES, please list medications you are allergic to and the problem experienced, along with the level of severity (mild, moderate, severe):***

_____***mild/moderate/severe*** _____***mild/moderate/severe***

_____***mild/moderate/severe*** _____***mild/moderate/severe***

□ NO

***4.* Do you smoke now?** □ YES □ NO

Have you ever been a smoker? □ YES □ NO

Do you use any other form of Tobacco? □ YES □ NO

Vital Signs height _____ weight _____ BP ____/____ Pulse _____