

Patient Health History

Today's Date [/ /] Signature of Patient _____

Patient Title: (check one) [] Mr. [] Mrs. [] Ms. [] Miss [] Dr. [] Prof. [] Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

By providing my email address, I authorize my doctor to contact me via the email address (es) provided.

Which email address would you like us to use to communicate with you? (Check one) [] Home [] Work

Contact Method (check one)

[] Primary Phone [] Secondary Phone [] Mobile Phone [] Home Email [] Work Email

Date of Birth [/ /] Age _____ Gender (check one) [] Male [] Female [] Unspecified

Marital Status (check one) [] Single [] Married [] Other SSN _____

Employment Status (check one)

[] Employed [] FT Student [] PT Student [] Other [] Retired [] Self Employed

Race (check one)

[] White [] Black/African American [] Hispanic [] American Indian/Alaskan Native
[] Asian [] Asian Indian [] Chinese [] Filipino
[] Japanese [] Korean [] Vietnamese [] Native Hawaiian or other Pacific Island
[] Samoan [] Guamanian or Chamorro [] Other _____ [] I choose not to specify

Multi-Racial (check one) [] Yes [] No [] Unknown

Ethnicity (check one) [] Hispanic or Latino [] Not Hispanic or Latino [] I choose not to specify

Preferred Language (check one)

[] English [] Spanish [] American Sign Language [] Chinese [] French [] German
[] Tagalog [] Vietnamese [] Italian [] Korean [] Russian [] Polish
[] Arabic [] Portuguese [] Japanese [] French Creole [] Greek [] Hindi
[] Persian [] Urdu [] Gujarati [] Armenian [] I choose not to specify

