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**FEDERAL REQUESTED INFORMATION THAT YOUR PHYSICIAN
IS NOW REQUIRED TO RECORD**

PATIENT NAME _____ DATE _____ CHART # _____

RACE

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> White |
| <input type="checkbox"/> Refused to Report | <input type="checkbox"/> More than one Race |

ETHNICITY

- | | |
|--|---|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino |
| <input type="checkbox"/> Refused or Unreported | |

PREFERRED LANGUAGE

- | | |
|----------------------------------|---------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Other: _____ |
|----------------------------------|---------------------------------------|

SMOKING STATUS

- | | |
|---|--|
| <input type="checkbox"/> Current every day smoker | <input type="checkbox"/> Current some day smoker |
| <input type="checkbox"/> Former smoker | <input type="checkbox"/> Never smoker |
| <input type="checkbox"/> Unknown | |

MEDICATIONS

Please check any of the following that you are currently taking (within the last three days).

- | | | |
|--|--|--|
| <input type="checkbox"/> NSAID (non-steroidal anti-inflammatory) | <input type="checkbox"/> Plavix, Agrenox, Ticlid | |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Anti-depressant _____ |

PNEUMONIA VACCINE

If you are 65 years or older, have you **ever** received a pneumococcal vaccination?

- Yes No

APPOINTMENT NOTIFICATION PREFERENCE

If you are 65 or older, what is the preferred means of contacting you regarding follow-up appointments?

- Phone Email _____ Mail

HYPERTENSION

Have you ever been diagnosed with or been treated for high blood pressure? Yes No