



Patient Extra Demographics

Patient Name: _____
Last First Middle

Date of Birth: _____

To comply with government standards relating to our electronic health record software we are required to capture certain demographic elements. Please help us so our records will be complete by answering the following questions. Thank you.

Race?

| | |
|--------------------------|----------------------------------|
| <input type="checkbox"/> | American Indian or Alaska Native |
| <input type="checkbox"/> | Asian |
| <input type="checkbox"/> | Native Hawaiian |
| <input type="checkbox"/> | Black or African American |
| <input type="checkbox"/> | White/Caucasian |
| <input type="checkbox"/> | Hispanic or Latino |
| <input type="checkbox"/> | Other Race |
| <input type="checkbox"/> | Other Pacific Islander |
| <input type="checkbox"/> | Prefer not to report |

Ethnicity?

| | |
|--------------------------|----------------------|
| <input type="checkbox"/> | Hispanic |
| <input type="checkbox"/> | Non-Hispanic |
| <input type="checkbox"/> | Prefer not to report |

Preferred language?

| | |
|--------------------------|-------------------------|
| <input type="checkbox"/> | English |
| <input type="checkbox"/> | Other |
| <input type="checkbox"/> | Indian (Includes Hindu) |
| <input type="checkbox"/> | Spanish |
| <input type="checkbox"/> | Russian |

Smoking Status

Are you a smoker? Yes No

Please check one

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | Current Smoker |
| <input type="checkbox"/> | Former Smoker |
| <input type="checkbox"/> | Never Smoker |
| <input type="checkbox"/> | Current Every Day Smoker |
| <input type="checkbox"/> | Current Some Day Smoker |
| <input type="checkbox"/> | Smoker, Current status |
| <input type="checkbox"/> | Unknown if ever smoked |

Signature: _____ Date: _____