PATIENT NAME: _____

EMAIL ADDRESS: _____

HEIGHT: _____ WEIGHT: _____

SMOKING INFO, CHECK WHICHEVER IS APPROPRIATE:
SMOKE NOW ____ EVERYDAY _____ OCCASIONAL _____

DO NOT SMOKE NOW BUT WAS A PREVIOUS SMOKER ____

NEVER SMOKED _____

PLEASE CHECK ONE FROM EACH CATEGORY BELOW:

RACE:			ETHNICITY:		
	PATIENT DECLINED	____		PATIENT DECLINED	____
	AMERICAN INDIAN	____		HISPANIC OR LATINO	____
	ASIAN	____		NOT HISPANIC\LATINO	____
	AFRICAN AMERICAN	____			
	NATIVE HAWAIIAN	____			
	WHITE	____			

PREFERRED LANGUAGE:		
	PATIENT DECLINED	____
	DUTCH	____
	ENGLISH	____
	FRENCH	____
	GERMAN	____
	GREEK	____
	ITALIAN	____
	JAPANESE	____
	PORTUGUESE	____
	RUSSIAN	____
	SPANISH	____

MEDICATIONS:

ALLERGIES & REACTIONS TO ANY MEDICATIONS: