

EMR Questionnaire

Name : _____ DOB : _____

Date of Service: _____ Medical Record # : _____

Primary Language (Circle One) English Spanish Italian Russian Mandarin Hebrew Other.._____

Race (Circle One) Black or African American White or Caucasian American Indian Asian
 Hawaiian or Pacific Isle Hispanic or Latino Unknown Refused To Answer

Ethnicity (Circle One) Hispanic or Latino Non-Hispanic Unknown Refused to Answer

Smoking Status (Circle One) Current Every Day Smoker Current Some Days Smoker Former Smoker Never Smoked Refused

Which of the following conditions currently apply to you? (Circle One or more)

<u>Heart</u>	<u>Thyroid</u>	<u>Stomach</u>	<u>Brain/Nero</u>	<u>Lungs</u>	<u>Urology</u>	<u>GYN</u>	<u>Joint/Bone</u>
Artherosclerosis	Graves Disease	Barrett's Disease	Cerebral Palsy	Asthma	Prostate Cancer	Endometriosis	Joint Pain
Aneurysm	Goiter	Celiac Disease	Neuropathy	Sarcoidosis	Bladder Cancer	Infertility	Arthritis
Aortic Valve Disorder	Hyperglycemia	Cirrhosis	Fibromyalgia	Lung Cancer	Incontinence	Cervical Cancer	Lupus
Chest Pain	Diabetes 1	Gerd-Reflux	Bell's Palsy	COPD	Renal Cyst	Ovarian Cancer	Gout
Cong Heart Fail	Diabetes 2	Hiatal Hernia	Migraines	Scleroderma	Kidney Stones	Cervical Dysplasia	Osteoarthritis
Arrhythmia	Addison's Disease	Pancreatitis	Stroke	Positive PPD	Acoustic Neuroma	Hepatitis	
Atrial Fibrillation	Hyperthyroidism	Ulcer	Alzheimer's Disease	Pneumonia	Renal Failure	Breast Cancer	
Hypertension	Thyroid Cancer	Crohn's Disease	Vertigo	Reactive Airway Disease			
Heart Disease	Thyroid Disease	IBS	Seizures	Sleep Apnea			
Tachycardia	Hyperthyroidism	Colitis	Parkinson's Disease				
Hypercholesterolemia	Hashimoto's Disease		Spine Disorder	NONE			
	Hypothyroidism						

Blood

AIDS High Blood Pressure
 HIV High Cholesterol
 Mononucleosis Anemia
 Blood Clots

Oth-
er: _____

Please circle all current medications that you are taking.

Accupril	Benedryl	Diltiazem	Glyburide	Levothyoxine	Metformin	Omeprazole	Prednisone	Simvastatin	Warfarin
Aciphex	Capropril	Femara	Hydrochlorothiazid	Levoxyol	Naproxen	Oxycodone	Premarin	Singulair	Zocor
Advair	Cardizem	Flomax	Hydrocortisone	Lexapro	Nasacort	Oxycontin	Prempro	Spiroinolactone	Zoloft
Albuterol	Coumadin	Flonase	Hyzaar	Lipitor	Nasonex	Paxil	Prevacid	Synthroid	Zyrtec
Allegra	Cozar	Fosamax	Insulin	Lisinopril	Nexium	Pepcid	Priosed	Tamoxifen	
Amoxicillin	Crestor	Fosinopril	Ibuprofen	Lopressor	Nifedipine	Plavix	Propranolol	Tenormin	
Aspirin	Decadron	Glimepirde	Labetalol	Loratadine	Norvasc	Pravachol	Proventil	Throxine	
Atenolol		Glucophage	Lasix	Lunesta	Novastan	Pravastain	Reglan	Toprol	NONE

Oth-
er: _____

Medication Allergies: (Circle One or more)

Allegra Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs IV Contrast Gadolinium Products

Other _____ / **NONE**