Name:_____ **DOB:**_____ **Date:**_____

Due to new government mandated regulations we must have you complete this form. PLEASE ANSWER ALL QUESTIONS and check which apply.

SOCIAL HISTORY:

Do you exercise? **Yes or No** **(CIRCLE ONLY ONE)**
If yes, How many times ? _____ ____ PER Day or Week or Month

Do you drink caffeine? (CIRCLE) Coffee/Tea/Soda **Yes or No**
If yes, How many drinks? _____ PER Day

Do you smoke? **Yes or No**
If yes, How many packs? _____ PER Day or Week or Month
If former smoker what date did you quit? ____/____/____

Do you drink alcohol? **Yes or No**
If yes, How many drinks? _____ PER Day or Week or Month

Do you use other substances, ex: Snuff / Chew tobacco? **Yes or No**

ETHNICITY:

____ Hispanic or Latino ____ Not Hispanic or Latino
____ Unknown ____ Declined to Specify

RACE:

___ American Indian/Alaskan Native
___Asian Indian
___Asian Other
___Black or African American
___Chinese
___ Declined to Specify
___ Filipino
___ Guamanian or Chamorro
___ Hawaiian Native
___ Japanese
___ Korean
___ Other
___ Pacific Islander/other
___ Samoan
___Vietnamese
___ Unknown
___ White

PREFERRED LANGUAGE _____

MUST give local Pharmacy information:

Pharmacy Name:_____
Street: _____ **City:**_____
Phone #: _____

PREFERENCE FOR APPOINTMENT VERIFICATION

(Circle One) Phone or Email or Text
EMAIL ADDRESS: _____