PEDIATRIC AFFILIATES, P.A.

SPECIALIZING IN INFANTS, CHILDREN, & ADOLESCENT MEDICINE

To ensure that we have the most current information on our patients, please take a minute to answer the following questions.

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

What is the race of the patient? (Check any that apply)

_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White
_____ Refused to Report / Unreported

What is the ethnicity of the patient?

_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Refused to Report / Unreported

What is the primary language of the patient? _____

What is your preferred notification method? _____ Phone _____ Postal Mail

What is your preferred pharmacy? Name: _____

Address: _____ **City:** _____

Does the patient take any regularly prescribed medications? _____ Yes _____ No
If yes, please list them.

Medication Name	Strength	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the patient have any allergies (including food, medication and environmental)?

_____ Yes_____ No If yes, please list them. _____

_____

Does the patient have any chronic conditions? ____ Yes _____ No. If yes, please explain.

_____

If the patient is 13 years or older, does he/she smoke? _____ Yes _____ No

_____ _____ / _____ / _____
Signature (Parent / Guardian) **Date**

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