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ELECTRONIC HEALTH RECORD (EHR) UPDATE FORM

In order for our office to comply with newly adopted Electronic Health Records (EHR) standards, please fill out the required information:

Last Name_____First Name_____MI____DOB_____/_____/_____

Street_____City_____State_____Zip_____Phone(____)_____-_____

Mobile(____)_____-_____Work(____)_____-_____email:_____ @_____

Ethnicity: **( ) non- Hispanic** **( ) Hispanic** **( ) Not Specified**

Preferred Language: **( ) English** **( ) Spanish** **( ) Other**

Race: **( ) African or African-American** **( ) Asian or Asian American**
( ) Caucasian or European American **( ) Native American or Native Alaskan**
( ) Native Hawaiian or other Pacific Islander **( ) Other Race**

Primary Care Provider: _____,_____ Phone(____)_____-_____
(City,State)

Pharmacy: _____,_____ Phone(____)_____-_____
(City,State)

Medications: (1)_____Dosage _____(6)_____Dosage _____

(2)_____Dosage _____(7) _____Dosage _____

(3) _____Dosage _____(8) _____Dosage _____

(4) _____Dosage _____(9) _____Dosage _____

(5) _____Dosage _____(10) _____Dosage _____

Medication Allergies: (1)_____ .

(2)_____

Height: _____ft. _____in

Office Use:

Past Surgeries: (1)_____

Weight:_____lbs.

Pulse_____

(2)_____

Do you Smoke ( ) yes ( ) no

BP_____/_____