NAME:_____DATE:_____

DATE OF BIRTH:_____Phone:_____

SMOKING STATUS:

Never smoked Former smoker Current smoker (decline)

It is required that we ask the following questions. (It is your right to decline to answer.)

Physician to be seen:

RACE: Native American/American Indian – African American – Asian – Caucasian - Other - (declined)

ETHNICITY: Hispanic – Non-Hispanic - (declined)

PREFERRED LANGUAGE: English, Spanish, Portuguese, Arabic, French, Hindi, Italian, German