Angel Williamson IMAGING CENTER
a place for hope, health and happiness

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DEMOGRAPHICS CHECKLIST
AS REQUIRED BY GOVERNMENT REGULATIONS FOR EMR

PATIENT'S NAME: _____ DOB: _____

GENDER: __Male __Female CELL PHONE: _____

EMAIL ADDRESS: _____DATE_____

1. ETHNICITY: Hispanic or Latino___
   Not Hispanic or Latino___

2. LANGUAGE: English___ Other _____
   Spanish___ Decline___
   French___

3. RACE: White___ American Indian or Alaska Native___
   Black___ Native Hawaiian or other Pacific Islander___
   Asian___ Other Race_____
   Unknown___ Decline___

4. SMOKING STATUS: _____Never Smoked
   _____Current Smoker _____ Pack(s) per day _____ Number of years
   _____Former Smoker _____ Pack(s) per day _____Number of years

5 MEDICATION LIST:

NAME	DOSAGE	TIMES PER DAY	HOW LONG ON MEDS?

6 **LIST DRUG ALLERGIES:**

DRUG	REACTION	Please check type of reaction: VERY MILD	MILD	MODERATE	SEVERE

(**office use only:** CHART #_____)

01.06.15cw

06.15.15cw/vl

Review:

Revised: