



SCREENING PATIENT INFORMATION

ORGANIZATION: _____

DATE OF VISIT: _____

(FIRST NAME) (MI) (LAST NAME)

DATE OF BIRTH: _____

(ADDRESS)

(CITY) (STATE) (ZIP) (COUNTY)

AGE _____ SEX M F ETHNICITY WHITE BLACK HISPANIC ASIAN NATIVE AMERICAN

PHONE HOME (____) _____ CURRENT WORK (____) _____

SS #: _____ MARITAL STATUS _____ COUNTRY OF BIRTH _____

NAME AND PHONE NUMBER OF YOUR PERSONAL PHYSICIAN _____

IN CASE OF EMERGENCY NOTIFY _____

ARE YOU A MEMBER OF A UNION? YES NO UNION AND LOCAL #: _____

FOR OFFICE USE ONLY	
IH INVOLVEMENT:	<input type="checkbox"/> YES involved in planning and execution of screening
OTHERS AT RISK:	<input type="checkbox"/> YES