Patient Name Date

Student ID# DOB Age

Gender: Male / Female / Transgender / Decline to state Ethnicity

Health Insurance: Yes or No, if yes: Private / Medi-Cal / Family Pact / Medicare (for Seniors) / Unsure

E-mail address

Blood Transfusion No Yes Anemia…… No Yes Heart Disease/Stroke.. No Yes Pneumonia…… No Yes

Arthritis…….. No Yes Epilepsy/Seizures…….No Yes High Blood Pressure….