

Patient Name: _____

DOB: _____

DEMOGRAPHIC QUESTIONNAIRE

Race:

- | | |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Refused to Report/Unreported |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Undefined |
| <input type="checkbox"/> More than one race | <input type="checkbox"/> White |
| <input type="checkbox"/> Native Hawaiian | |

Ethnicity:

- | | |
|---|---|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Refused to Report/Unreported |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Undefined |

Primary Language:

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian |
| <input type="checkbox"/> English | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Finnish | <input type="checkbox"/> Polish |
| <input type="checkbox"/> French | <input type="checkbox"/> Russian |
| <input type="checkbox"/> French Creole | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Hebrew | <input type="checkbox"/> Other: |
-