CFF ANNUAL FORM

To be completed by patient/parent

Date: ____/___/

YOUR NAME:		
DATE OF BIRTH:	ZIP CODE:	
EMAIL ADDRESS:		
INSURANCE:		
What type of Insurance do you have? Private Medicare Medicaid State special needs program TriCare/Military Indian Health Service Other: No insurance		
Are you under a PARENT'S INSURANCE? Yes No		
Do you receive ASSISTANCE FROM A PATIENT ASSISTANCE PROGRAM? Yes No		
DEMOGRAPHICS:		
BIOLOGICAL SEX AT BIRTH: Male Female		
RACE/ETHNICITY: Decline to answer		
White Black/African American Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Some other race Two or more races: select all that apply White Black/African American Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander		
Hispanic Origin: Yes No		
MARITAL STATUS (Age 18 or older): Single Living together Married Separated Divorced Widowed Decline to answer		
EMPLOYMENT (Age 18 or older): Part Time Full Time Homemaker Full Time Employment Unemployed Student Disabled Retired Decline to answer		

EDUCATION LEVEL: PATIENT (You): Lega then high school Wigh school Some College College Master Destarate		
less than high school High school Some College College Master Doctorate Decline to answer Patient's Father:		
less than high school High school Some College College Master Doctorate Decline to answer		
Patient's Mother: less than high school High school Some College College Master Doctorate Decline to answer		
Patient's Spouse: less than high school High school Some College College Master Doctorate Decline to answer		
How many people are in your household, including yourself? Decline to answer		
What is your estimated ANNUAL HOUSEHOLD INCOME?		
\$ Decline to answer		
SMOKING		
Did you smoke cigarettes? No Yes, less than 1 pack per day Yes, 1 or more pack per day decline to answer Not applicable		
Does anyone in your household smoke cigarettes? Yes No Decline to answer		
How often are you exposed to secondhand smoke? Never Daily several times per week several times per month or less declined to answer Unknown		
VAPING		
Did you use electronic cigarettes (vaping)? Yes No Decline to answer		
How often did you vape? Everyday Some days Not at all Decline to answer		
IMMUNIZATION		
Did you receive the influenza vaccine this year? Yes No Decline to answer		
Did you receive COVID vaccine? Yes Decline to answer		

PULMONARY		
Do you use OXYGEN? Yes No If YES: Continuous Nocturnal and/or with	exertion During exacerbation As needed	
Do you use any NON-INVASIVE VENT? (assisted breathing, BiPap, CPAP, etc): Yes No		
Did you have a CHEST X-RAY this year? Yes No		
EYE CARE		
Did you get checked for cataracts this year? Yes No Unknown		
If you have diabetes, did you have a retinal exam done by an ophthalmologist? Yes No Unknown Not applicable		
PREGNANCY: Not applicable		
Are you or were you PREGNANT this year? Yes No Decline to answer If YES, date of last LMP:/ If YES, outcome of pregnancy: Live stillbirth spontaneous abortion therapeutic abortion undelivered decline to answer Date of outcome://		
IF AGE 2 YEAR or LESS: Not applicable		
Did your child attend DAYCARE this year? Did your family receive genetic counseling this year? Was your child given SYNAGIS this season (Sept - Jan)? Yes No Unknown Yes No Unknown		
Please return completed pediatric patient	Please return completed adult patient forms to:	
New York Medical College	Dr. Timothy Collins 21 Reade Place, suite 1000 Poughkeepsie, NY 12601	