

# MEDiC Data Project

<b>Visit Date:</b> ____/____/____		<b>Race/Eth:</b> <input type="checkbox"/> _1 Caucasian <input type="checkbox"/> _5 Native Amer. <input type="checkbox"/> _2 Latino/a <input type="checkbox"/> _6 Other <input type="checkbox"/> _3 African Amer. <input type="checkbox"/> _7 Hmong <input type="checkbox"/> _4 Asian	
<b>Clinic:</b> <input type="checkbox"/> _1 Southside <input type="checkbox"/> _2 Grace <input type="checkbox"/> _3 Salvation Army <input type="checkbox"/> _4 ARC House <input type="checkbox"/> _5 Michele Tracy <input type="checkbox"/> _6 Safehaven	<b>DOB:</b> ____/____/____ <b>Gender:</b> <input type="checkbox"/> _1 Male <input type="checkbox"/> _2 Female <b>Employed:</b> <input type="checkbox"/> _1 Yes <input type="checkbox"/> _2 No <b>Insured:</b> <input type="checkbox"/> _1 Yes <input type="checkbox"/> _2 No If " <u>Yes</u> " <input type="checkbox"/> _1 Public <input type="checkbox"/> _2 Private	<b>Language:</b> <input type="checkbox"/> _1 English <input type="checkbox"/> _4 Chinese <input type="checkbox"/> _2 Spanish <input type="checkbox"/> _5 Other <input type="checkbox"/> _3 Hmong	

<b>Chief Comp #1:</b>	
Chief Comp #2:	
<b>Diagnosis #1:</b>	
Diagnosis #2:	
Diagnosis #3:	
<b>Prescription #1:</b>	
Prescription #2:	
Prescription #3:	

<b>Meds Source:</b> (Check all that apply)	<input type="checkbox"/> _1 Drug cabinet samples <input type="checkbox"/> _2 Drug cabinet stock bottles <input type="checkbox"/> _3 Medic stamp Rx <input type="checkbox"/> _4 Pharmacy-sponsored patient <input type="checkbox"/> _5 Patient paid for Rx
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<b>Referral:</b> <input type="checkbox"/> _1 NE Clinic <input type="checkbox"/> _2 BSP Clinic <input type="checkbox"/> _3 UW Specialty Clinics <input type="checkbox"/> _4 Eye Clinic <input type="checkbox"/> _5 X-Ray St. Mary's <input type="checkbox"/> _6 Labwork St. Mary's <input type="checkbox"/> _7 Planned Parenthood <input type="checkbox"/> _8 Well Women <input type="checkbox"/> _9 Emergency Room <input type="checkbox"/> _10 PT at Southside	<input type="checkbox"/> _11 Dermatology at Southside <input type="checkbox"/> _12 Dental <input type="checkbox"/> _13 PT at Salvation Army <input type="checkbox"/> _14 Wingra Clinic <input type="checkbox"/> _15 Blue Bus <input type="checkbox"/> _16 Dane Cty. Mental Health <input type="checkbox"/> _17 <input type="checkbox"/> _18 (Check all that apply) <input type="checkbox"/> _19 <input type="checkbox"/> _20
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**Notes:** \_\_\_\_\_

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