

# Ohio Department of Health

## Maternal and Child Health Integrated Data System (MCHIDS) – Demographic Record

Date Completed \_\_\_\_/\_\_\_\_/\_\_\_\_

New CFHS client record

Update CFHS client record

### Patient Record

First Name*		Middle Name		Last Name*		Suffix		
Alias		Patient's Maiden Name						
Address*		City*		State*	Zip*		County*	
Birth Address		Birth City		Birth State	Birth Zip		Birth County	
Social Security Number		Primary Telephone		Email Address			Plurality	Birth Order
Date of Birth*		<input type="checkbox"/> Unknown DOB		Country of Birth			Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Date of Death		Cause of Death						
Ethnicity* <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other		Primary Language Other		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married <input type="checkbox"/> Unknown		
Select Race(s)* <input type="checkbox"/> White <input type="checkbox"/> Filipino <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chomorro <input type="checkbox"/> American Indian of Alaska Native <input type="checkbox"/> Korean <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown								
Notes								

### Relationships Record

Relationship Type* <input type="checkbox"/> Parent/Caregiver <input type="checkbox"/> Foster Parent <input type="checkbox"/> Daughter <input type="checkbox"/> Mother <input type="checkbox"/> Grand Parent <input type="checkbox"/> Brother <input type="checkbox"/> Guardian <input type="checkbox"/> Surrogate Parent <input type="checkbox"/> Sister <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Step Parent <input type="checkbox"/> Son <input type="checkbox"/> Undetermined								
First Name*		Middle Name		Last Name*		Suffix		<input type="checkbox"/> Do Not Contact
Alias		Maiden Name			Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married <input type="checkbox"/> Unknown			
Primary Address*		City*		State*	Zip*		County*	
Social Security Number		Telephone Type <input type="checkbox"/> Primary <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Secondary <input type="checkbox"/> Work		Telephone		Email Address		
Date of Birth		Country of Birth						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other		Primary Language Other		
Race <input type="checkbox"/> White <input type="checkbox"/> Filipino <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chomorro <input type="checkbox"/> American Indian of Alaska Native <input type="checkbox"/> Korean <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown								