

Meaningful Use Patient Questionnaire

Patient Name _____ Date of Birth _____ Date _____

In an effort to improve the quality of care or patients receive, Diagnostic Radiology Associates (DRA) has implemented an electronic health record and is participating in the Meaningful Use Initiative. The data we are collecting below will help DRA efficiently and safely care for you, reduce health disparities, and improve care coordination between DRA, your primary care physician and local hospitals. Please take a moment to answer the following very important questions regarding you and your overall healthcare. Thank you for choosing DRA.

Please circle your ethnic background: Hispanic/Latino | Not Hispanic/ Latino

What is your preferred language? _____

Please circle your race:

American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander

Asian or Asian American

White

Black or African American

Other _____

No response

Smoking Status: Current every day | Current some day smoker | Former | Never | Unknown

What is your current Height? _____ **Weight?** _____

Adults aged 50 years and older: Did you have a flu shot during the flu season? Yes No

Please list your Past Medical History (Diabetes, high blood pressure, high cholesterol, heart issues etc.)

Please list all medications with dosage taken on a routine basis

_____ **I am not currently taking any medication**

Medication AND Dosage	Medication AND Dosage	Medication AND Dosage

Are you allergic to any medications? Yes No

If yes, please list the medication then the reaction you had for example: rash, hives, itching, throat swelling low blood pressure, etc

Medication	Reaction

I am aware that within three business days I can request an electronic copy of my images and report by asking DRA for a CD ROM. In addition, by listing my email and phone number below I am requesting access to DRA's patient portal where I can view, download and transmit my clinical health information and clinical summary online. Currently my clinical summary contains only the medical information that was collected from me today, not my images or report. However by listing my email and phone number I will be able to view my images and reports when they are made available online to me in the near future.

Telephone # _____

Patient/Guardian Signature _____ **Email** _____

Receptionist and Technologist initials _____

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