Spring Pediatrics 10750 Columbia Pike #230 Silver Spring, MD 20901

Meaningful Use Patient Questionnaire

We apologize for the inconvenience. The Federal government is requiring patients to fill out the Meaningful Use form for additional information to comply with new Federal regulations. Meaningful Use is the set of standards defined by the Centers for Medicare and Medicaid Services (CMS). The Meaningful Use regulations are put in place so that your medical records have the most complete and accurate information possible. This information is reported as a general number with no personal information passed on from us, much like the census the government will use it for demographic information. Again, we apologize for the inconvenience and thank you for your patience.

First Name:__________________________ **Last Name**:__________________________ **DOB:** ____/_____/_____

E-Mail Address: _________________________________ **Preferred Language: ___________________________**

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other Polynesian / More than one Race / **I Decline to Answer**

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / **I Decline to Answer**

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

☐ Cigarettes ☐ Other Type ______________________

Are you currently taking any medications? (Please include regularly used over the counter medications) ☐ **None**

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

***If more than 3 medications, please continue list on back of page**

Do you have any medication allergies? ☐ **None**

Medication Name	Reaction	Onset Date	Severity (circle one)
			Mild / Moderate / Severe
			Mild / Moderate / Severe
			Mild / Moderate / Severe

Do you have any other allergies? (i.e. nuts, milk, pollen, latex, …) ☐ **None**

Name	Reaction	Onset Date	Severity (circle one)
			Mild / Moderate / Severe
			Mild / Moderate / Severe
			Mild / Moderate / Severe

Do you have any chronic medical conditions? ☐ **None**

(i.e. ADD/ADHD, asthma, diabetes, cholesterol, high blood pressure…)

Name	Status	Onset Date/Age	Resolved Date/Age	Severity (circle one)
	Active /Inactive /Resolved			Mild / Moderate / Severe
	Active /Inactive /Resolved			Mild / Moderate / Severe
	Active /Inactive /Resolved			Mild / Moderate / Severe

Patient/Parent Signature_______________________________ Relation to Patient _________________________

Print Name____ Date:______________________