



### Patient Data Collection Form for Meaningful Use

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b>Smoking Status</b></p> <p><input type="checkbox"/> Current every day smoker</p> <p><input type="checkbox"/> Current some day smoker</p> <p><input type="checkbox"/> Former smoker</p> <p><input type="checkbox"/> Never smoker</p>	<p><b>Ethnicity:</b></p> <p><input type="checkbox"/> Hispanic or Latino</p> <p><input type="checkbox"/> Not Hispanic or Latino</p> <p><input type="checkbox"/> Decline to State</p>
<p><b>Race:</b></p> <p><input type="checkbox"/> American Indian or Alaska Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Other Race</p> <p><input type="checkbox"/> Decline to State</p>	<p><b>Preferred Language:</b></p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> French</p> <p><input type="checkbox"/> Italian</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Portuguese</p> <p><input type="checkbox"/> Russian</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Unknown/Other</p>
<p><b>Medication Allergy List (include reaction if known)</b></p> <p><input type="checkbox"/> None</p> <hr/> <hr/>	
<p><b>Medication (include dose if known)</b></p> <p><input type="checkbox"/> None</p> <hr/> <hr/>	

Rev: 10/03/13