Huntington-Hill Imaging Centers

Huntington-Hill Breast Center
Arcadia-Huntington Drive

Jim & Eleanor Randall Breast Center
A Huntington Hospital & Hill Imaging Partnership

MEANINGFUL USE QUESTIONNAIRE

☐ **Huntington-Hill Imaging Center** Cordova
☐ **Huntington-Hill Imaging Center** Fair Oaks
☐ **Huntington-Hill Imaging Center** Glendora
☐ **Huntington-Hill Imaging Center** West Covina
☐ **Huntington-Hill Breast Center** Arcadia
☐ **Jim & Eleanor Randall Breast Center**

Legal Name: *(first)* _____ *(last)* _____ **Name Used:** _____

Date of Birth: _____ **Sex at Birth:** ☐ Male ☐ Female

Legal Sex: ☐ Male ☐ Female
(If different than at birth)

Gender Identity: ☐ Male ☐ Female ☐ Other

Preferred Pronoun: _____

Insurance companies and legal entities typically require the legal name and sex listed on your insurance to be used on documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different, please let us know. Sex at birth is required to assist medical staff in appropriate interpretation of your radiologic studies.

The American Recovery and Reinvestment Act of 2009 contains the Health Information Technology for Economic and Clinical Health Act (HITECH). This regulation requires Huntington-Hill Imaging Center to document your health history and communication preferences in an electronic format. These questions must be asked each time you visit our facility, regardless of your exam or diagnosis.

All information will be kept confidential as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1. What is your race/ethnicity?

☐ White/Caucasian ☐ Black/African American ☐ Asian
☐ Hispanic ☐ Hawaiian/Pacific Islander ☐ Other ☐ Prefer not to answer

2. What is your preferred language?

☐ English ☐ Spanish ☐ Chinese (Mandarin/Cantonese) ☐ Other ☐ Prefer not to answer

3. What is your Height? _____ **What is your Weight?** _____ **Lbs.**

4. In regards to smoking, are you? ☐ Never Smoker ☐ Unknown if ever smoked
☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Light tobacco smoker (9 or less) ☐ Heavy tobacco smoker (10+) ☐ Former Smoker

# of packs/day _____ x # of years smoked _____ = _____ pack years

5. Are you currently taking any medications?

☐ No ☐ Yes - Please list them here with ordering physician and dosage ☐ Prefer not to answer

Medication:	**Dosage:**	**Physician:**

6. Do you have any allergies? Example - medications, food, environment, cats, etc.

☐ No ☐ Yes - Please list them here with type of reaction ☐ Prefer not to answer

Type:	**Reaction severity:**
	☐ Minor ☐ Moderate ☐ Major
	☐ Minor ☐ Moderate ☐ Major
	☐ Minor ☐ Moderate ☐ Major

7. By providing your e-mail address below you will have access to your medical records online through our patient portal.

E-mail: (Please print clearly)

_____

The Hill Medical Corporation will not sell, transfer or otherwise use your e-mail address for any purpose other than patient portal access or secure communication with you regarding your healthcare.

_____ _____

Signature **Date**

Thank you for taking the time to fill out our questionnaire. We appreciate being your choice for your imaging needs.