Usability Pre Session Questionnaire

ID#: _____
Today's Date: _____

Thank you for participating in our usability testing. Please answer this brief questionnaire about your background and use of electronic medical records.

1. How old are you? _____ years

2. Gender (circle one):
   Female Male

3. What is your current level of clinical training (circle one)?

PGY 1	PGY 2	PGY 3	Fellow	Attending/Faculty	NP	PA

4. How many years of medical practice have you had since completing medical/nursing school?

   _____ years

5. For how long have you been using (insert name of tool)?

   _____ years

6. Have you ever used any other electronic medical records (circle one)?

   Yes No

7. How comfortable are you using (insert name of tool) (circle one number, 1 - 5)?

Not at all comfortable				Extremely comfortable
1	2	3	4	5

8. How comfortable are you using Best Practice Alerts in (insert name of tool) (circle one number, 1 - 5)?

Not at all comfortable				Extremely comfortable
1	2	3	4	5

9. How comfortable are you using Smart Sets in (insert name of tool) (circle one number, 1 - 5)?

Not at all comfortable				Extremely comfortable
1	2	3	4	5