History for Chest X-Ray

Patient sticker

Patient name: _____ **MRN:** **(Office Use Only)** _____

Do you have, or have you recently experienced any of the following symptoms?

☐ Y	☐ N	**Fever**	☐ Y	☐ N	**Swelling, mass or lump in head or neck**
☐ Y	☐ N	**Fatigue/Tiredness**	☐ Y	☐ N	**Hiccup**
☐ Y	☐ N	**Unexplained weight loss**	☐ Y	☐ N	**Snoring/Yawning**
☐ Y	☐ N	**Shortness of breath**	☐ Y	☐ N	**Nausea**
☐ Y	☐ N	**Cough**	☐ Y	☐ N	**Heartburn**
☐ Y	☐ N	**Chest pain**	☐ Y	☐ N	**Difficulty swallowing**
☐ Y	☐ N	**Bronchitis**	☐ Y	☐ N	**Dizziness**
☐ Y	☐ N	**Wheezing**	☐ Y	☐ N	**Smoker**
☐ Y	☐ N	**Asthma**			
☐ Y	☐ N	**Edema/Swelling of face or body, arms, legs**			
☐ Y	☐ N	**History of smoking?** *If yes, how long?* _____			

Heart Disease

☐ Y	☐ N	**Angina (chest pain due to heart disease)**	☐ Y	☐ N	**History of heart attack**
☐ Y	☐ N	**Irregular heartbeat**	☐ Y	☐ N	**History of heart failure**
☐ Y	☐ N	**Heart murmur**	☐ Y	☐ N	**Heart surgery**
☐ Y	☐ N	**Coronary artery disease**			
☐ Y	☐ N	**Other heart disease; please indicate:** _____			

Have you ever had, or do you currently have any of the following problems?

☐ Y	☐ N	**High blood pressure**	☐ Y	☐ N	**History of cancer;** *type:* _____
☐ Y	☐ N	**Tuberculosis (TB)**	☐ Y	☐ N	**C.O.P.D. (Chronic Pulmonary Obstructive Disease, or Emphysema)**
☐ Y	☐ N	**Valley Fever**	☐ Y	☐ N	**Other lung disease;** *please indicate:* _____

☐ Y ☐ N **Are you having an X-Ray because of a past abnormal X-Ray?**

☐ Y ☐ N **Have you ever had a prior chest X-Ray?**

Where: _____

When: _____

Patient Signature: _____ **Date:** _____

Tech initials: _____