ADVANCED MEDICAL IMAGING

History for Chest X-Rays

Patient name: ______________________________ **MRN:** ________________

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

☐ Yes ☐ No Fever
☐ Yes ☐ No Fatigue/Tiredness
☐ Yes ☐ No Unexplained weight loss
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Do you become short of breath walking up two flights of stairs?
☐ Yes ☐ No Cough
☐ Yes ☐ No Chest pain
☐ Yes ☐ No Bronchitis
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Asthma
☐ Yes ☐ No Swelling, mass or lump in head or neck
☐ Yes ☐ No Hiccup
☐ Yes ☐ No Edema/Swelling of face or body, arms, legs
☐ Yes ☐ No Snoring/Yawning
☐ Yes ☐ No Nausea
☐ Yes ☐ No Heartburn
☐ Yes ☐ No Difficulty swallowing
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Smoker
☐ Yes ☐ No History of smoking? If yes, how long ______________________________

Heart Disease

☐ Yes ☐ No Angina (chest pain due to heart disease)
☐ Yes ☐ No Irregular heartbeat
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Coronary artery disease
☐ Yes ☐ No History of heart attack
☐ Yes ☐ No History of heart failure
☐ Yes ☐ No Heart surgery
☐ Yes ☐ No Other heart disease; please indicate: ______________________________

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

☐ Yes ☐ No High blood pressure
☐ Yes ☐ No History of cancer; Type: ______________________________
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Valley Fever
☐ Yes ☐ No COPD (Chronic Pulmonary Obstructive Disease, or Emphysema)
☐ Yes ☐ No Other lung disease; please indicate: ______________________________

☐ Yes ☐ No Are you having an X-Ray because of a past abnormal X-Ray?

☐ Yes ☐ No Have you ever had a prior chest X-Ray?
Where: ______________________________
When: ______________________________

Patient Signature: ______________________________ **Date:** ________________

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