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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