Chest Evaluation Questionnaire

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What complaints or symptoms caused you to see your doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had these issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke?  NO  YES

Have you ever had Chest surgery?  NO  YES If so, What was done?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any other imaging exams of your chest (MRI, CT, X-Ray, etc.)

If so, What was done and Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Approximate Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

Have you had any of the following?

 Cough  Shortness of Breath

 Fever  Painful Breathing

 Tightness in your Chest  Cancer if so, Where? \_\_\_\_\_\_\_\_\_\_\_

 Emphysema/COPD  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Our Female Patients**

Are you or do you think you may be pregnant?  NO  YES

 Technologist’s Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_