CHEST X-RAY QUESTIONNAIRE

What procedure or operation are you scheduled to have: ____________________________

Please check if you have any of the following:

- Arteriosclerosis
- Asthma
- Bronchitis
- Cardiac Pacemaker
- Chest pain / Angina
- Coronary Artery Bypass
- Cough
- Diabetes
- Emphysema
- Heart Disease
- High Blood Pressure (HBP)
- Kidney Disease / Renal Failure

Patient’s Name (print) ____________________________ Signature ____________________________ Date ______ Time ______

Staff Name / Title ____________________________ Signature ____________________________ Date ______ Time ______