CEDARS-SINAI®

S. MARK TAPER FOUNDATION
IMAGING CENTER

CHEST X-RAY QUESTIONNAIRE

PATIENT I.D.

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

NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF STAFF (please print)	**SIGNATURE OF STAFF**	**DATE**	**TIME**