Trinitas Diagnostic Imaging
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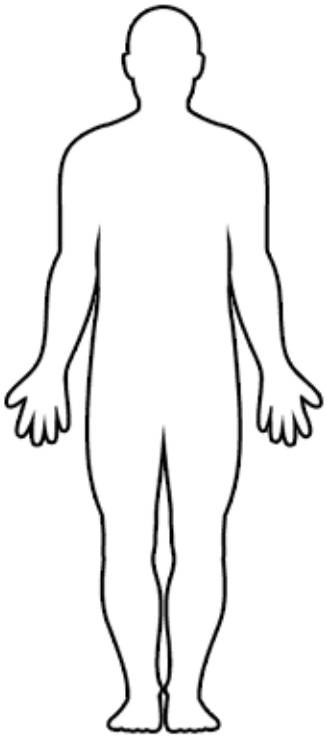
Neck & Chest Questionnaire

If you're coming to our center for this test, print this page, fill out the form and bring it in with you on the day of your appointment.



Please circle the portion of your body that is in pain.

FIRST NAME

LAST NAME

AGE WEIGHT DATE

WHAT WAS YOUR CHIEF COMPLAINT WHEN YOU VISITED YOUR DOCTOR?

ANY HISTORY OF CANCER ? ☐ YES ☐ NO

IF YES, WHERE?

IF YES, WHEN WAS IT FOUND?

ANY MASS OR SWELLING IN THE CHEST OR NECK? ☐ YES ☐ NO

IF YES, WHERE?

ANY HISTORY OF THYROID PROBLEMS? ☐ YES ☐ NO

IF YES, DESCRIBE?

DIFFICULTY SWALLOWING/SHORTNESS OF BREATH? ☐ YES ☐ NO

ANY CHEST OR NECK SURGERY? ☐ YES ☐ NO

IF YES, WHEN?

WHAT TYPE OF SURGERY WAS DONE?

ANY OTHER MEDICAL CONDITIONS ? ☐ YES ☐ NO

IF YES, DESCRIBE?

DESCRIBE YOUR GENERAL HEALTH:

DO YOU SMOKE? ☐ YES ☐ NO