

## CHEST INFORMATION SHEET

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Do you have the following systems:

If yes, please describe (dull, sharp, etc.)

**YES**

**NO**

Difficulty breathing \_\_\_\_\_

Chest pain \_\_\_\_\_

Heartburn \_\_\_\_\_

Cough \_\_\_\_\_

Asthma \_\_\_\_\_

Prior Pneumonia \_\_\_\_\_

Chronic bronchitis or emphysema \_\_\_\_\_

Prior chest surgery \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

Any other prior surgery \_\_\_\_\_

What type: \_\_\_\_\_

Other information you feel may be helpful:

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