TRI-CITY RADIOLOGY

RESPIRATORY Imaging Evaluation Form

The following information is necessary to comply with the federally mandated ICD-10 billing requirements, which takes effective Oct. 1st 2015.

NAME:______________________________ **Age:**_____ **Weight:**______ **Date:** ________

1. What was your chief complaint when you visited your doctor? ______________________________

   ____

   What is the **specific body part** we are imaging (chest, sinus, neck)? ______________________

2. If you have pain; please indicate **where**: ______________________________

   * **How long** has it been hurting? ________________

3. Do you currently smoke? **YES** or **NO** Have you ever smoked? **YES** or **NO**

   # of Cigarettes Per Day: ________ # of Years Smoked: ________

4. Do you have a **cough**? **YES** or **NO** If yes, for how long? __________

5. Any recent **weight loss** or **fever**? **YES** or **NO**

6. ANY **surgeries** in the general area (head, neck, chest)? **YES** or **NO** ______________________

7. Are you experiencing **Shortness of breath**? **YES** or **NO** If yes, for how long? ____________

8. Any personal history of **Brain** or **Neck Surgery**? **YES** or **NO**

   If yes, When? ____________ Where? ______________________

9. Do you have a history of **cancer**? **YES** or **NO** If yes, please list:

   a. Type(s) of cancer: ______________________
   b. Diagnosis date(s): ______________________
   c. Treatments you have completed for it (radiation, chemotherapy): ____________

      ____

10. **Trauma/injury** involving the area we are imaging today? **YES** or **NO**

    Date of Injury: __________

    What activity were you doing when you were injured? (skiing, mva, fall) : ________________

    Where did this trauma/injury occur (exact location)? ______________________

    Please describe the injury: ______________________________

11. Have you had any other imaging tests done on the body part we are imaging today? **YES** or **NO**

    X-Rays? ____________ When & Where? ______________________

    CT Scan? ____________ When & Where? ______________________

    MRI Scan? ____________ When & Where? ______________________

    Bone Scan? ____________ When & Where? ______________________

    Ultrasound?____________ When & Where? ______________________

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Female Patients Only:

Are you pregnant? **YES** or **NO** ***If Yes, NOTIFY THE TECH IMMEDIATELY***

If No, please give the date of your LMP: ________________
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