PATIENT QUESTIONNAIRE for **INJURY/ACCIDENT**

NAME: _____ D.O.B:___/____/___ AGE: ____ SEX: M/ F
(Last) (First)

WT: ____ lbs HT:___ft.___in REFERRING
PHYSICIAN:_____

- **If Injury or Work-Related:** Date of Injury: _____

  Circle ONE from EACH column of the 3 columns below:

Place of Occurrence	**Activity**	**Intention**
Home	Sports (type) _____	Accident
School	Playing	Assault
Work	Slip/Fall (type) _____	Self-inflicted/harm
Military	Motor Vehicle/Auto Accident	
Other _____	Other _____	

- What caused the injury? Please be specific and describe occurrence.

  _____

- **If Auto Accident**: Date of Accident: _____ Were you the Driver, Passenger, Pedestrian? (Circle)

  Type of Vehicle: _____ What did vehicle hit? _____ Was another vehicle involved? _____

- Describe what occurred in detail:

  _____

  _____

CHEST XRAYS ONLY:

PRE-OP: Please note surgery/procedure to be performed: _____

SMOKER: Circle one:	FORMER	CURRENT
ASTHMA: Circle either or both:	Worsening (Exacerbation)	Status Asthmaticus
COPD: Circle applicable condition:	Acute Worsening (Exacerbation)	Acute Respiratory Infection

I acknowledge that all the information given is accurate and thereby consent to having the study with or without an injection of contrast performed on me and ordered by my physician.

_____ **Date:____/____/____** **Technologist Initials:** _____
Patient Signature