Merced College
Allied Health
Chest X-Ray Questionnaire

Name:_____ **Date of Birth:**_____

Do you have any of the following symptoms?

Cough lasting more than 3 months?	☐ Yes	☐ No
Coughing up blood?	☐ Yes	☐ No
Unexplained fever?	☐ Yes	☐ No
Night sweats?	☐ Yes	☐ No
Unintentional weight loss?	☐ Yes	☐ No
Excessive fatigue?	☐ Yes	☐ No

Comments:_____

_____

By signing below, I CONFIRM this patient's condition is adequate for them to fully participate in the Allied Health Program.

Date	Health Care Professional	Facility Stamp OR Attach Provider Business Card