



LUNG SCREENING QUESTIONNAIRE

Name: _____ Date of Birth: _____ Last 4 numbers of SS#: _____

Referring Physician: _____ Height: _____ Weight: _____

Medical history

(Check all that apply) Diabetes High blood pressure Smoking Kidney disease/failure Asthma

COPD Dialysis Multiple myeloma Adrenal Gland Tumor Heart Disease Lung Disease

List any major surgeries: _____

Prior studies

Have you had previous related imaging studies done? Yes No What part(s) of your body? _____

Where did you get these exams done? _____ What year? _____

Type of exam: X-Ray CT MRI Ultrasound Nuclear Medicine PETCT

How many CT or Cardiac Nuclear Medicine studies have you had in the last 12 months? _____

1. Are you between the ages of 55 and 77? Yes No
2. Do you have any signs or symptoms of lung cancer? Yes No
3. Do you have any prior history of lung cancer? Yes No
4. Have you ever been diagnosed with any other type of cancer? Yes No

If yes, please describe _____

What is your smoking status? Current smoker Former smoker Unknown Never a smoker

Current Smokers / Former Smokers

1. How many years have you been smoking? _____
2. How many packs a day? _____
3. How many years since you quit? _____

Please initial all that apply:

_____ I acknowledge that I was provided smoking cessation education (pamphlet) today.

_____ I acknowledge that my ordering physician has counseled me on lung screening and shared decision making for my health.

*****This section is for staff use only*****

1. CTDI _____
2. DLP _____
3. Number of pack years _____ (1 pack daily for a year = 1 pack year)

Patient Signature: _____ Date: _____

Baptist M&S Staff Full Signature: _____ Date: _____