YOUR IMAGE IS IN OUR HANDS

LOW DOSE CT LUNG SCREENING QUESTIONNAIRE

Name:_____ Date:_____

Date of Birth: _____ Age:_____ Sex: M F

Medicare ID:_____ SSN:_____

Height:_____ Weight:_____

Have you had a previous Chest CT Scan? Yes No

**If yes When_____Where_____

Are you presently suffering from any acute symptoms like a new cough, new shortness of breath or unexplained weight loss? **Yes No
If yes please explain

_____

---Smoking history---

Please circle one: CURRENT FORMER

If FORMER, how many years ago did you stop smoking? _____

If CURRENT, how many cigarettes do you smoke daily? _____

How many years have you smoked? _____

Do you have a personal history of lung cancer? YES NO

Technologist:

Pack Year Calculation: _____ (Packs smoked per day **X** years as a smoker)

CTDivol:_____ DLP:_____