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:___________