Lung Screening / Follow-Up CT Patient Questionnaire

St Vincents Riverside Southside Clay St Johns Imaging Center Arlington ER Westside ER

Optimal Forbes Southside Clay Mandarin Westside St Johns Town Center Orange Park

Patient Name: MMI: Age:

Y N ______ Do you currently smoke cigarettes? (Do not include cigar smoking or second hand smoke.)

______ If you are not a current cigarette smoker, how many years ago did you stop smoking cigarettes?

______ How many packs of cigarettes per day do you smoke or how many packs per day did you smoke when you smoked?

______ How many years have you smoked cigarettes or how many years did you smoke cigarettes when you smoked?

SECTION 1 Check any of the following symptoms that you currently have today.

______ Change in your normal cough
______ Change in your normal shortness of breath
______ Significant chest pain
______ Coughing up blood (hemoptysis)
______ Unintentional weight loss
______ Fever

Many patients have a daily cough or regular shortness of breath. Only check those symptoms or you are experiencing a change in your cough or shortness of breath.

SECTION 2 Check any of the following history that applies to you.

______ Family history of lung cancer. If so, in whom: ______________________
______ Personal history of lymphoma, head and neck (throat) cancer or esophageal cancer
______ Personal history of COPD, ILD (interstitial lung disease) or pulmonary fibrosis
______ Personal exposure to radon
______ Personal exposure to any of the following as part of your employment (circle all that apply)

asbestos	chromium	cadmium	silica	coal smoke
arsenic	nickel	beryllium	diesel fuel	soot

Y N ______ Do you feel this screening test will benefit your health?

Patient Signature: Date:

By signing this form you agree that the above attestation is accurate and you will follow up with care at your Primary Care Provider's / Pulmonologist's office.

Tech Name: Pack Years: