QUESTIONNAIRE FOR LUNG CANCER CT SCREENING

Please complete this brief questionnaire to help identify if you are at high risk for lung cancer. If you meet the recommended criteria you will be offered a Low dose-CT scan which can help to identify concerns within your lungs. This test can be billed to your insurance or is available at $99 discounted rate. The results will be given to you by your physician.

Date:_____

Name:_____ Daytime Phone Number:_____

What is your current age?_____ Date of Birth_____/_____/_____

What is your gender? ☐Male ☐Female

Do you have a history of smoking? ☐Yes ☐No

Do you currently smoke? ☐Yes ☐No

If you have quit, has it been less than 15 years ago? ☐Yes ☐No

What is the total number of years you have smoked?_____

How many cigarettes smoked per day?_____

Has a doctor ever told you that you had COPD, emphysema, bronchitis, pneumonia, pulmonary fibrosis, coronary arterial disease, congestive heart failure, peripheral or vascular disease? ☐Yes ☐No

Have you ever had any type of cancer (excluding basal or squamous cell skin cancer) ☐Yes ☐No

☐ Lymphoma ☐ Bladder Cancer ☐ Head & Neck Cancer ☐ Esophageal Cancer ☐ Other

Have any of your immediate family (parents, siblings or children) had lung cancer? ☐Yes ☐No

Have you had prolonged exposure to second hand smoke? ☐Yes ☐No

If yes, explain:_____

Please check below any new respiratory symptoms that have appeared in the past 6 months:
☐Coughing ☐Wheezing ☐Shortness of breath ☐Coughing up blood

You may have exposure to especially hazardous chemicals if you have been engaged in any of the following occupations. Please mark any that apply:

☐Asbestos worker ☐Bartender ☐Ceramic worker
☐Chemist ☐Drywall ☐Glass worker
☐Manufacturing ☐Masonry worker ☐Metal worker
☐Painter ☐Printer ☐Sandblasting
☐Truck Driving ☐Uranium mining

To your knowledge have you been exposed to radon, silica, canuium, asbestos, arsenic, beryllium, chromium, diesel fumes, or nickel? ☐Yes ☐No

Have you had a CT of chest within the past 12 months? ☐Yes ☐No

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Office Use:

Physician Reviewed:_____ Date:_____

Reviewing Physician: Please fax completed questionnaire to James E. Cary Cancer Center
Attention: Screening Nurse
Fax: (573) 406-5803

JAMES E. CARY CANCER CENTER
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