

**CT LUNG SCREENING**

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| **THIS SECTION TO BE COMPLETED BY PATIENT** | | | | |
| **NAME:** | | | **DOB:** | |
| Are you pregnant or possibly pregnant? | Yes | | No | |
| Have you ever been diagnosed with lung cancer? | Yes | | No | |
| Have you ever been regularly exposed to secondhand smoke? | Yes | | No | |
| Do you have any previous chest x-rays? | Yes | | No | |
| If yes, where? | | | | |
| Do you have a history of lung disease? | Yes | | No | |
| If yes, please explain: | | | | |
| Have you ever had lung surgery? | Yes | | No | |
| If yes, please explain: | | | | |
| Have you ever had a lung biopsy? | Yes | | No | |
| If yes, please explain: | | | | |
|  | | | | |
| **IF YOU HAVE A HISTORY OF SMOKING, PLEASE COMPLETE THIS SECTION** | | | | |
| At what age did you begin smoking? | | | | Years old |
| How many packs per day? | | | | Packs/day |
| How many years have you been smoking? | | | | Years smoking |
| Are you currently a smoker? | Yes | | No | |
| If no, when did you quit? | | | | Date (MM/YY): / |
|  | | | |  |
| **Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **MDI Technologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |

6/26/18