NWR NorthwestRadiologyNetwork "Trusted Imaging Since 1967"

Low-Dose Lung Cancer Screening Sheet

Patient Name:____ DOB:___________________ Height ______________

Patient Phone Number:_______________________ Patient Alt. Phone Number:______________ Weight _____________

Do you have a primary care physician? Yes ☐ No ☐ If yes, Dr. ______________________ Race ________________

Please answer the following questions:

1) Are you a current or former smoker between the ages of 55 – 77? Yes ☐ No ☐

2) Do you currently smoke (or quit less than 15 years ago) an average of one pack of cigarettes per day for 30 years or more (2 pack for 15 years etc.)? Yes ☐ No ☐

3) Have you smoked at least a pack of cigarettes per day for 20+ years? Yes ☐ No ☐

4) Do you currently smoke (cigarettes, cigars or pipe)? Yes ☐ No, but did in the past ☐ Never smoked ☐

If yes, how many years have you smoked?__________ If no, when did you quit?__________ How much per day?_____

If yes, how much do you smoke per day?___________ If no, how many years did you smoke?_______

5) Do you have any of the following additional cancer risk factors?

a. Family history of lung cancer? Mother ☐ Father ☐ Sibling ☐ Child ☐ Other Relative____________________

b. Personal history of chronic lung disease? COPD ☐ Chronic Bronchitis ☐ Pulmonary Fibrosis ☐ Emphysema ☐

c. Occupational exposure to lung carcinogens? Arsenic ☐ Asbestos ☐ Beryllium ☐ Cadmium ☐ Chromium ☐ Diesel Fumes ☐ Nickel ☐ Silica ☐

d. Radon Exposure: Documented Residential? ☐ **OR** Occupational? Mining ☐ Firefighter ☐ Military ☐

e. Personal history of cancer (excluding known metastatic disease): Lung Cancer greater than five years ago ☐ Lymphoma ☐ Head & Neck ☐ Esophageal ☐ Bladder ☐ Colon ☐ Kidney ☐ Pancreas ☐ Stomach ☐ Cervix ☐ Other smoking related Cancers ☐ ____

f. Second Hand Smoke Exposure? Yes ☐ No ☐ Unsure ☐

6) Have you had any surgeries on your heart or lungs? Yes ☐ No ☐ If yes, please specify__________________________

7) Do you have any symptoms of which we should be aware of? Yes ☐ No ☐

If yes, please specify ____

8) Please indicate if you have experienced any of the following sign and symptoms:

Chronic cough: Yes ☐ No ☐ Voice hoarseness: Yes ☐ No ☐ Chest pain: Yes ☐ No ☐

Shortness of breath: Yes ☐ No ☐ Headache and swelling of the face: Yes ☐ No ☐

Wheezing when you breathe: Yes ☐ No ☐ A droopy eyelid and/or blurred vision: Yes ☐ No ☐

9) Education Level: 8th Grade or less ☐ 9th -11th grade ☐ High School Graduate or equivalency ☐

Post High School Training other than college ☐ Associate degree/some college ☐ Bachelor's degree ☐
Graduate or professional school ☐ Other, please specify________________ Prefer not to answer ☐

10) Have you had any prior imaging of your chest? Yes ☐ No ☐ If yes, where and when did you have this imaging?

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