

## LUNG SCREENING

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

Why are you having this test? \_\_\_\_\_

Have you had: (Please circle YES OR NO)

- Cancer (any form)                      **YES**   or   **NO** If yes, what type? \_\_\_\_\_
- Lung nodule or "spot"                      **YES**   or   **NO**
- Tuberculosis (TB)                      **YES**   or   **NO**
- Granulomas disease or fungal disease                      **YES**   or   **NO**
- Emphysema or COPD                      **YES**   or   **NO**
- Chronic Bronchitis                      **YES**   or   **NO**
- Asthma                      **YES**   or   **NO**
- Pneumonia                      **YES**   or   **NO** When? \_\_\_\_\_
- Surgery in the chest                      **YES**   or   **NO** When? \_\_\_\_\_
- Have you had significant exposure to second hand smoke (living with a smoker)?                      **YES**   or   **NO**
- Are you a smoker? **YES**   or   **NO** If yes, age started? \_\_\_\_\_ Age stopped? \_\_\_\_\_
- Average number of packs per day \_\_\_\_\_                      I usually smoke:   **FILTERED**   or   **UNFILTERED**
- I smoke/smoked cigars   **YES**   or   **NO**                      I smoke/smoked a pipe   **YES**   or   **NO**
- I have been exposed to asbestos **YES**   or   **NO**                      If yes, how many years \_\_\_\_\_
- Have you had a chronic cough?   **YES**   or   **NO**
- Have you coughed up any blood? **YES**   or   **NO**
- Do you have shortness of breath or wheezing? **YES**   or   **NO**

Have you had: (Please check all that apply)

- Previous CT (CAT) scan of the chest or lungs  
If checked when? \_\_\_\_\_ Where? \_\_\_\_\_
- Previous X-ray of the chest or lungs  
If checked when? \_\_\_\_\_ Where? \_\_\_\_\_
- Previous Pulmonary function test (breathing capacity test)  
If checked when? \_\_\_\_\_ Where? \_\_\_\_\_