LUNG CANCER SCREENING QUESTIONNAIRE

DIRECTIONS:
Lung cancer low-dose computed tomography screening has only been shown to benefit those who are at high risk. These questions help us measure risk and determine the degree to which screening might help reduce your risk of dying from lung cancer. Please complete the following form prior to your visit. If you have any questions, please call the program coordinator at 646-697-LUNG (5864).

DEMOGRAPHICS:
Name: ____________________________ Date of Birth: ________________
Preferred phone number: ____________________________ Email: __________
Sex: ☐ Male ☐ Female Height: ________________ Weight: ________________
Are you pregnant: ☐ Yes ☐ No Last menstrual cycle: ________________ ☐ Not applicable
Education level (optional):
☐ 8th grade or less ☐ 9-11th grade ☐ High school graduate or high school equivalency
☐ Post high school training (vocational/technical school) ☐ Associate degree/some college ☐ Bachelor’s degree
☐ Graduate or professional school ☐ Other, specify: ____________________________ ☐ Decline
If desired, please indicate your race/ethnicity (optional):
☐ Hispanic, Latino, or Spanish Origin ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Island ☐ White ☐ Other combination not described: ____________ ☐ Decline

CARE TEAM:
Primary Care Physician: ____________________________ Phone: ________________
Pulmonologist: ____________________________ Phone: ________________
Cardiologist: ____________________________ Phone: ________________
Referring Physician: ____________________________ Phone: ________________
How did you hear about the Lung Cancer Screening Program:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

MEDICATIONS:
Do you have a known allergy to: YES NO DETAILS (allergies and reactions)
Latex ____________________________
Iodine ____________________________
X-ray dye ____________________________
Medications ____________________________
Please list the medications you are currently taking:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Lung Cancer Screening Program

PAST MEDICAL HISTORY:
Do you have a personal history of: YES NO DETAILS (dates and treatment)
- Emphysema
- COPD
- Pulmonary fibrosis
- Cancer
- Radiation therapy to the chest
- Tuberculosis
Have you had exposure to: YES NO DETAILS (dates and type of exposure)
- Asbestos
- Dust
- Radon
- Other cancer causing agents
- Secondhand smoke

Do you currently work? Yes No Occupation: ____________________________________________
Do you currently smoke? Yes No Did you ever smoke? Yes No
Please indicate type of tobacco: Cigarettes Cigars Pipes Electronic cigarettes Other: __________
Please indicate amount smoked per day: ____________________________ Not applicable
Please indicate approximate Start Date: ________________ Quit Date: ________________ Not applicable
Please indicate whether you would like to be contacted about smoking cessation services: Yes No Initials: ___

If you currently smoke, please complete the following 3 questions:
Are you planning to quit smoking?
☑️ Within the next month ☐ Within the next 6 months ☐ Sometime in the future ☑️ I am not planning to quit

On a scale of 1 to 10, how IMPORTANT is it for you to quit smoking FOR GOOD?
☑️ 1 (Not at all important) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extremely important)

On a scale of 1 to 10, how CONFIDENT are you that you can quit smoking FOR GOOD?
☑️ 1 (Not at all confident) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Extremely confident)

PAST SURGICAL HISTORY:
Please indicate dates and types of surgery: ____________________________________________
__________________________________________________________________________________
### FAMILY HISTORY:
Please indicate your family members’ history of cancer:

<table>
<thead>
<tr>
<th>Family member</th>
<th>Age at onset/death</th>
<th>Type of cancer/cause of death</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### REVIEW OF SYSTEMS:
Please indicate if you are currently experiencing any of the following signs and/or symptoms:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>Recent change in weight</td>
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<tr>
<td>Fevers</td>
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<tr>
<td>Fatigue</td>
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<td>Shortness of breath</td>
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<td>Coughing up sputum/phlegm</td>
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<tr>
<td>Wheezing</td>
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<tr>
<td>Chest pain</td>
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</tbody>
</table>

### QUESTIONNAIRE COMPLETED BY:
Print Name: __________________________ Signature: __________________________ Date: __________________________