

Lung Cancer Screening Program

OFFICE USE ONLY	
Name:	_____
MRN:	_____
Date of birth:	_____

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:

	Send Report:	YES	NO	Initials
Primary Care Physician: _____ Phone: _____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonologist: _____ Phone: _____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiologist: _____ Phone: _____		<input type="checkbox"/>	<input type="checkbox"/>	_____
Referring Physician: _____ Phone: _____		<input type="checkbox"/>	<input type="checkbox"/>	_____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	_____
X-ray dye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list the medications you are currently taking: _____

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PAST MEDICAL HISTORY:

Do you have a personal history of:	YES	NO	DETAILS (dates and treatment)
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation therapy to the chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had exposure to:	YES	NO	DETAILS (dates and type of exposure)
Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dust	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radon	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other cancer causing agents	<input type="checkbox"/>	<input type="checkbox"/>	_____
Secondhand smoke	<input type="checkbox"/>	<input type="checkbox"/>	_____

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: _____

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FAMILY HISTORY:

Please indicate your family members' history of cancer:

Family member	Age at onset/death	Type of cancer/cause of death

REVIEW OF SYSTEMS:

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

	YES	NO	DETAILS
Recent change in weight	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coughing up sputum/phlegm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	_____

QUESTIONNAIRE COMPLETED BY:

Print Name: _____ Signature: _____ Date: _____

OFFICE USE ONLY:
Questionnaire reviewed by:
Print Name: _____ Signature: _____ Date: _____
Notes: _____

