Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

OFFICE USE ONLY
Name:
MRN:
Date of birth:

LUNG HEALTH QUESTIONNAIRE

DIRECTIONS:

Please complete the following form prior to your visit. If you have any questions, please call the program coordinator at 646-697-LUNG (5864). You and your referring physician will automatically receive your lung imaging results. If you would like results sent to additional providers, please complete the additional records request form.

DEMOGRAPHICS:

Name: _____ Date of Birth: _____

Preferred phone number: _____ Email: _____

How did you hear about the Radiology Consultation Services: _____

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

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: _____

_____

_____

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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: _____

_____

_____

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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			
Fevers			
Fatigue			
Shortness of breath			
Coughing up sputum/phlegm			
Wheezing			
Chest pain			

QUESTIONNAIRE COMPLETED BY:

Print Name: _____ Signature: _____ Date: _____

OFFICE USE ONLY:

Questionnaire reviewed by:

Print Name: _____ Signature: _____ Date: _____

Notes: _____

_____

_____

_____

_____

_____