



A Member of the Hackensack Meridian Health Network

PATIENT NAME: _____ DATE OF BIRTH: _____

Height _____ Weight _____

Have you had a CT Chest or CT Lung Screen in the past? Yes No _____

Have you had a Chest X-Ray within the last 3 years? Yes No _____

Do you currently smoke cigarettes? Yes No

Total years smoked (even if you quit)? _____

How long since you quit smoking? _____

Average number of packs you smoke (d) per day? _____

Do you have a history of Cancer? Yes No

Diagnosed with COPD? Yes No

Diagnosed with Pulmonary Fibrosis? Yes No

Do you have a family history of lung cancer? Yes No _____

First degree/ extended relative with history of lung cancer? Yes No _____

ANY EXPOSURE TO (circle all that apply):

Soot Nickel Asbestos Coal Radom Silica Beryllium
Diesel Fumes Cadmium Smoke Arsenic Chromium Secondhand Smoke

Any possibility of pregnancy? Yes No Don't know

First date of last menstrual period? _____

Signing below indicates that you have read and understand this form and have completed it to the best of your ability.

Patient or Legal Representative Signature _____

Technologist Signature _____ Date _____

CTDI _____

DLP _____