FIRELANDSHEALTH
Firelands Regional Medical Center

LDCTQUES

Patient Label

LUNG CANCER SCREENING QUESTIONNAIRE

Patient Name: _____ D.O.B. _____

1. Have you had a Pulmonary Function Test (PFT) within the last year? (Circle) **Yes** **No**
   If yes, where was the test performed? _____

2. Are you a **current or former** smoker? (Please circle one)
   How many packs per day? _____
   If former smoker, in what year did you quit? _____

3. Occupational History? (Please list below)
   _____

4. Any previous exposure to asbestos or other cancer causing agents? (Circle) **Yes** **No**
   If other, please explain _____

5. Have you ever had a Chest X-ray or Chest CT that was "positive" for a lung nodule or abnormal growth? (Circle) **Yes** **No**
   If yes, when and where was the image taken? _____

6. Is there a personal and/or family history of cancer? (Circle) **Yes** **No**
   If yes, please specify _____

7. Past Medical History? (Please list below)
   _____
   _____
   _____

8. Family History? (Please list below)
   _____
   _____
   _____

I attest that the above information is true and correct to the best of my knowledge and that I have not withheld any information that would affect the outcomes of and/or decisions for any further screening, testing or procedures in relation to Firelands Regional Medical Center's Lung Cancer Screening Program. (Please sign below)

Patient Signature _____ Date _____

Witness Signature _____ Date _____