IMAGING CENTER at CYPRESS
LUNG SCREENING PATIENT HISTORY

Name: _____ **Date of Birth: _____**
(print)

Current Weight _____lbs **Height _____ feet _____ inches**

Do you smoke Yes No

If you quit, what year _____

How many years HAVE you or DID you smoke _____ (or age when started smoking)

How many cigarettes DO you or DID you smoke a day _____ (20 per pack)

Have you ever been diagnosed with COVID-19 Yes No

Have you ever been tested for COVID-19 Yes No

Testing Date _____ Results _____

Have you ever been diagnosed with cancer Yes No

If yes, what type and year _____

Have you ever been diagnosed with any of the following:

COPD	Yes	No
Emphysema	Yes	No
Pulmonary Fibrosis	Yes	No
Coronary Artery Disease - CAD	Yes	No
Congestive Heart Failure - CHF	Yes	No
Peripheral Vascular Disease - PVD	Yes	No
Lymphoma	Yes	No
Asthma	Yes	No

Have you ever had high occupational exposure to agents known to cause lung cancer –
Circle all that apply: Diesel Fumes, Asbestos, Arsenic, Beryllium, Chromium, Nickel, Silica, Cadmium, Coal Smoke, Soot
OTHER – Please list agent(s) _____

Do you have 1st degree family history of lung cancer Yes No Unknown
(E.g. father, mother, brother, sister, child)

Any other family history of lung cancer: Yes No Unknown
(E.g. grandparent, uncle, aunt, cousin)

Do you have documented high exposure levels to radon Yes No

Have you had a previous CT Low Dose Lung Screening exam(s): Yes No

If yes, when and where _____

List lung surgeries or biopsies; heart surgery or heart stent placements and year if known:

_____

What is your Race _____ Prefer not to answer _____

Are you Hispanic or Latino Yes No Prefer not to answer _____

Patient Signature:_____ **Todays Date**: _____