CT LUNG SCREENING

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: _____

PATIENT #: _____
PATIENT NAME: _____
DOB: _____ / AGE: _____ / SEX: _____

*** **Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask.** ***

HEIGHT:	WEIGHT:

□ Yes □ No – Are you a current smoker?

If ***YES***, how many years have you smoked? _____

How many packs/day do you smoke? _____

If ***NO***, when did you quit? _____

How many years did you smoke? _____

How many packs/day did you smoke? _____

□ Yes □ No – Have you had a CT lung screening exam before? If yes, when? _____

□ Yes □ No – Have you and your doctor discussed smoking cessation (quitting)?

□ Yes □ No – Has your doctor discussed the benefits and risks of having the CT Lung Screening Exam?

Do you have any of the following:

□ Yes □ No – Cancer If yes, type: _____
□ Yes □ No – Pulmonary fibrosis
□ Yes □ No – COPD
□ Yes □ No – Coronary artery disease
□ Yes □ No – Congestive heart failure
□ Yes □ No – Peripheral vascular disease
□ Yes □ No – Emphysema
□ Yes □ No – Peripheral vascular disease

** Please note that this examination will only evaluate lung tissue. This exam will not evaluate any other anatomy. **

TECHNOLOGIST USE ONLY

Comments: _____

_____

_____CT Technologist:_____Ext:_____

I attest that the information on the form above, including technologist comments above, is correct and complete to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the CT procedure that I am about to undergo.

Signature of Person Completing Form: _____ **Date:** _____

If Form Completed by Someone Other than the Patient (Print name):_____

Relationship: _____