



CHEST CT PATIENT QUESTIONNAIRE

For Office Use Only
Place Patient ID label here

Patient name _____ Date of birth _____ Female Male

Referring physician(s) _____ Exam date _____

Chief complaint (shortness of breath, blood in sputum, fever, etc.) _____

Please list all medications you are currently taking (especially new medications over the last 6 months) _____

Y N History of asthma? If yes, please explain. _____

Y N Smoker

Y N Ex-smoker? If yes, date stopped _____

HISTORY OF CANCER

Y N Personal history of cancer? If yes, what area/type? _____

Y N Family history of cancer? If yes, what area/type and what family member? _____

EXPOSURE HISTORY

Y N Pets (cats, dogs, birds, any newly acquired pets) _____

Y N Farmer/gardener _____

Y N Work history (prior exposure to asbestos, work in a mine, textile manufacturing, construction) _____

Y N New job, recent change in work environment _____

Y N History of Sarcoid?

Y N History of Lupus?

Y N History of Rheumatoid Arthritis?

Y N History of any connective tissue disorder?

Y N History of pulmonary embolism?

Y N History of deep venous thrombus in the legs?

Y N Are you immunocompromised?

Y N Have you ever lived in the Midwest or Southwest United States?

Y N History of recent travel outside the U.S.? If yes, where? _____

Patient signature: _____ Date: _____

FOR OFFICE USE ONLY

Remarks: _____

Technologist: _____ Date: _____