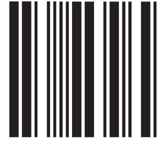
WASHINGTON RADIOLOGY ASSOCIATES, P.C.

CHEST CT SCAN



Patient Questionnaire

Acct # ______________________ Tech's Init./Exam Date _____/_____

Name ______________________ DOB ______________ Sex ________

Referring Physician(s) ______________________________________

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

____

Medications (especially new medications over the past 6 months) ______________________

____

History of asthma: ______________________________________

Smoker: ○ Yes ○ No Ex-Smoker? ○ Yes ○ No Date Stopped: ____________

History of cancer:

Personal history of cancer? ○ Yes ○ No If yes, what area/type? ______________________

____

Family history of cancer? ○ Yes ○ No If yes, what area/type and what family member?

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Exposure History:

○ Yes ○ No Pets (cats, dogs, birds, any newly acquired pets) ______________________

○ Yes ○ No Farmer/Gardner ______________________________________

○ Yes ○ No Work History (prior exposure to asbestos, work in a mine, textile manufacturing, construction) ______________________

○ Yes ○ No New job, recent change in work environment ______________________

○ Yes ○ No History of Sarcoid?

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Chest CT Scan

Patient Questionnaire Continued...

○ Yes ○ No History of Lupus?

○ Yes ○ No History of Rheumatoid Arthritis?

○ Yes ○ No History of any connective tissue disorder?____________________

○ Yes ○ No History of pulmonary embolism?

○ Yes ○ No History of a deep venous thrombus in the legs?

○ Yes ○ No Are you immunocompromised?

○ Yes ○ No Have you ever lived in the Midwest or Southwest United States?

○ Yes ○ No History of recent travel outside the U.S.?

If yes, where?______________________________

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Patient Signature Date