Imaging Excellence with Personalized Care

203.453.5123 • 1591 Boston Post Rd, Guilford, CT 06437
guilfordradiology.com

CT LUNG CANCER SCREENING

Name: ____

Date of Birth: _________________ Age: _________

Height: _____________ Weight: ____________

Have you had this procedure before? Yes _____ No _____

If yes, when and where? ____

Are you a smoker now? Yes _____ No _____

How long (years) have you smoked? ___________________________________

If no, did you ever smoke? Yes _____ No _____

If yes, when did you quit? ____

Previous lung surgery? Yes _____ No _____

Prior personal history of Lung Cancer? Yes _____ No _____

If yes, when was it diagnosed?_____________

Family history of Lung Cancer? Yes _____ No _____

How much did you or do you smoke per day on average?

____

Do you have any symptoms today (cough, back or chest pain, shortness of breath, etc.)Yes _____ No _____

If yes, explain: ____

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