Princeton Radiology
Excellence in Imaging

CT Chest Questionnaire

Name: _____ D.OB.____/____/____ Age: _____ Sex: M/F
(Last) (First)
WT: _____ HT:__ft. __in. Referring Physician: _____

- Please provide a summary of your symptoms specific to your exam today:_____
  _____
- Have you ever smoked? Yes ____ No____
  - If yes, how many years? ____ Aver # of packs a day? ____ Stopped smoking _____ years ago.
- Has your father, mother, brother or sister had lung cancer? Yes ____ No ____
- Do you have a history of emphysema, chronic bronchitis or pulmonary fibrosis? Yes ____ No____
- Have you or your spouse ever been exposed to asbestos at work? Yes____ No ____
- Do you have a work exposure to any of the following? Yes ____ No ____

  ☐ Asbestos ☐ Arsenic ☐ Beryllium ☐ Cadmium ☐ Chromium
  ☐ Coal smoke ☐ Diesel fumes ☐ Nickel ☐ Silica ☐ Soot
- Do you have a history of lung cancer, lymphoma, head/neck cancer or smoking related cancer? Yes ____ No ____
  If yes, circle which cancer type
- Have you had radiation therapy to our chest? Yes ____ No ____
- Where was your last chest x-ray taken? _____
- Have you ever had a CT Chest? Yes ____ No ____ If yes, where? _____
- Any surgery on area being imaged? Yes____ No____ If yes, when and what type?_____
- Are you experiencing any chest pain? Yes____ No____ If Yes circle if pain is severe / moderate / mild
- Do you have a history of surgery in the area being scanned? Yes ____ No ____
- Do you have a history of being diagnosed with cancer? Yes ____ No____ When?_____ Type?_____
- Have you been treated with either: ☐ Radiation or ☐ Chemotherapy? Date started_____ Completed_____
- Have you had a documented high exposure to radon? Yes ____ No ____
- Have you taken a drug call **AVASTIN**? ☐ YES ☐ NO *If Yes, when was the last time your received the drug AVASTIN?* _____
- Do you wear a Dexcom glucose monitor? Yes ___ No ___ ***If Yes, please inform your technologist before exam***

Female patients:

- Are you pregnant or possibly pregnant? Yes____ No____ Date of last menstrual period_____

I acknowledge that all the information given is accurate and thereby consent to have CT with or without an injection of contrast performed on me.

Patient's signature: _____ Date: ___/___/___Technologist Initials: _____

TECHNOLOGIST NOTES: _____

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