Marine Park Radiology, P.C.

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CAT Scan Questionnaire

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____

Type of CT Exam(s) to be performed: _____

What is the reason your doctor is sending you for this test? _____

_____

Have you ever had a CAT Scan? YES ☐ NO ☐

If Yes, specify which exam, and when and where it was performed:_____

_____

To further evaluate your study, Marine Park Radiology needs to conduct a search/review your CT exams performed at external, non-affiliated facilities within the 12 months, do you consent to this? Please detail above the facility where your previous studies were performed. YES ☐ NO ☐

Have you ever had any reaction to iodine? YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐ Date of last menstrual period: _____

Please fully complete the following history chart:

	Yes	No	Not Sure
Heart Disease			
Emphysema			
Asthma			
Bronchitis			
Diabetes			
Loss of Consciousness			
Kidney Problems			
Smoker/Former Smoker			

List any surgery you have undergone: _____

_____

Allergies? If Yes, list all: _____

List all medications you are currently taking: _____

_____

Additional comments: _____

_____

Signature: _____ Today's Date: _____

Low Dose CT Lung Screening Questionnaire & Order Form

Candidates should not have a diagnosis of lung cancer within the past 5 years.

Social Security:_____ Primary Care Physician: _____

Smoking Status: Current Smoker_____#packs a day Current Smoker_____ years

Former/quit_____ years ago Year Quit_____

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Category 1

1. Age 55-74 Years	☐ YES	☐ NO
2. Currently a smoker or have quit within 15 years	☐ YES	☐ NO
3. Have smoked at least a pack of cigarettes a day for 30+ years	☐ YES	☐ NO

Category 2

1. Age 50-74 Years	☐ YES	☐ NO
2. Have smoked at least a pack of cigarettes a day for 20+ years	☐ YES	☐ NO
3. Have one additional lung cancer risk factor, not to include Second hand smoke.	☐ YES	☐ NO

High Risk Factors *please check all that apply*

Family History of Lung Cancer:

A ❑ Mother ❑ Father ❑ Sibling ❑ Child

Personal History Of Chronic Lung Disease:

B List: _____

Personal Cancer History:

C List: _____

Has your referring physician provided you information for smoking cessation? ❑ Yes ❑ No

Is there documentation of shared decision making between you and your referring physician? ❑ Yes ❑ No