WASHINGTON RADIOLOGY

For Office Use Only
Place Patient ID label here

Chest CT Patient Questionnaire

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: _____

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Remarks: _____

_____

_____

Technologist: _____ Date: _____