# LUNG SCAN QUESTIONAIRE

MRN__________
DOB__________
DATE __________

PATIENT NAME________________________ ORDERING PHYSICIAN________________

1. DO YOU HAVE ASTHMA? YES NO
2. DO YOU HAVE COPD? YES NO
3. HAVE YOU EVERY SMOKED: YES NO

   IF YOU CURRENTLY SMOKE, HOW MUCH PER DAY? ______________
4. DO YOU USE INHALERS? YES NO
5. DIAGNOSIS OF HEART DISEASE? YES NO
6. ANY HISTORY OF BLOOD CLOTS:

   LUNGS: YES NO

   VEINS: YES NO
7. DO YOU HAVE CHEST PAIN? YES NO
8. ANY SHORTNESS OF BREATH? YES NO
9. HAVE YOU HAD ANY MAJOR ABDOMINAL OR ORTHOPEDIC SURGERY WITHIN THE PAST YEAR? YES NO
10. ANY PRIOR LUNG SCANS? YES NO

    WHERE/WHEN? ___________________________
11. ANY PRIOR CT SCANS? YES NO

    WHERE/WHEN? ___________________________
12. ANY RECENT CHEST X-RAYS? YES NO
13. ANY RECENT PULMONARY FUNCTION TESTS? YES NO