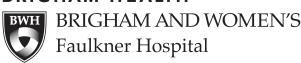
## **BRIGHAM HEALTH**



Name:			
DOB: _			
MRN:_			
	Interview Date:		

## Lung Cancer Risk Assessment Questionnaire

You have you decided to have a low dose chest CT screening examination after a shared decision making process with your physician. By enrolling in the Brigham and Women's Faulkner Hospital Lung cancer screening program you are willing to take part in follow up appointments. The best form of prevention is smoking cessation.

Our program is based on the United States Preventative Task Force recommendations. Patients that meet the following criteria may be scanned:

## **Requirements:**

Age: 55 - 80 (up to 77 Medicare)

Asymptomatic (no signs of symptoms of lung cancer)

Current smoker or one who has quit smoking within the last 15 years

Date of CT Screening: \_\_\_\_\_ Time: \_\_\_\_\_

Smoking history of at least 30 pack-years (one pack-year = One pack per day for one year; 1 pack = 20 cigarettes)

Age [Medicare 55-77 years, private insu	rance up to 80 years]:	Height:	Feet	_ Inches	Weight:	lbs.		
1. Have you developed new symptoms in the past 2 weeks [Patients should be asymptomatic but, the patient mother chronic cough due to smoking, patient should not have hemoptysis or weight loss greater than 15 lbs.]?								
*If yes, please explain						ı res		
2. Do you have a personal history of Lung Cancer? [Patient should not have had history of lung cancer] □ No □ Yes								
3. Have you had a prior chest CT [Should not have had Chest CT in the last 18 months]?					□ No □	] Yes		
*If yes, where?								
*If yes, have you had a prior lung cancer screening?					□ No □ Yes			
Please answer the following questions. Please check the appropriate box.	This risk assessment tool will	help the radi	ologist int	erpret yo	our examination	1.		
*Smoking History: ☐ Smoker	☐ Former Smoker *Please specify the last ye	ear you smol	ked					
	<b>*Former smokers,</b> if you you had <b>any</b> cigarettes d	u quit more uring your q	than 15 ye uit period	ears ago l ?	nave			
				No	☐ Yes ☐			
*For both current and former sn $\Box$ 1/2 pk/ day $\Box$	nokers, on <u>average</u> how n 3/4 pk/ day □1 pk/ day	, ,	•	o you si	noke(d)?			
Age at first cigarette	Age at last cigarette			= <b>To</b> 1	tal:			

<b>4. Have you been diagnosed with any other form of cancer in the last 5 years?</b> [Patient should not be \sum \text{No} \subseteq \text{Yes} under active cancer treatment]
*If so, please specify which type
*Check the form of treatment: $\square$ Surgery $\square$ Radiation $\square$ Chemotherapy
*Please specify the last year of treatment
5. Medical History — Do you have/had any of the following conditions?  □ COPD □ Asthma □ Chronic bronchitis □ Emphysema □ Tuberculosis (TB) □ Pulmonary Fibrosis □ Peripheral vascular disease □ Coronary Artery disease □ Congestive heart failure □ N/A
6. Has anyone in your immediate family (parent, sibling or child) been diagnosed with lung cancer? $\square$ No $\square$ Yes
*If yes, please specify Relation Age at diagnosis Died of cancer \( \subseteq \text{No} \subseteq \text{Yes} \)  Relation Age at diagnosis Died of cancer \( \subseteq \text{No} \subseteq \text{Yes} \)
7. Have you been exposed to second hand smoke exposure, if so:specify  ☐ Spouse ☐ Mother ☐ Father ☐ Workplace ☐ Other:
8. In your work or hobbies, have you ever been exposed to the following carcinogens for more than 8 hours a week for at least a year? Check all that apply.  □ Asbestos □ Radon Gas □ Silica □ Cadmium □ Arsenic □ Beryllium □ Chromium □ Diesel fumes □ Nickel □ N/A
9. Has your physician discussed quitting options? [required] □ No □ Yes
10. How did you hear about our program here at BWFH?
11. Would you be interested in partaking in future research [no additional scans]? $\square$ No $\square$ Yes
12. How may we contact you in follow-up?
□ Phone □ Morning □ Afternoon □ Evening
□ Email:
Your physician will receive the results of your CT exam. You may also see your results on patient gateway.  Please contact your physician with any questions.  Patient (Representative's) signature:
THIS SECTION TO BE COMPLETED BY HOSPITAL EMPLOYEE
Follow up is necessary. If for any reason the patient does not qualify notify the ordering physician or submit to the supervisor.
Protocol (Please check):   Routine Chest CT   Lung Cancer Screening CT
Scanner: Siemens Definition or Emotion Total DLP mGycm Total CTDIvol*mGy
Technologist signature:Date: Time: