BRIGHAM HEALTH

BRIGHAM AND WOMEN'S
Faulkner Hospital

Name: ____________________

DOB: ____________________

MRN: ____________________

Date of CT Screening: ____________________ Time: ____________________ 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
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 insurance 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 may have chronic cough due to smoking, patient should not have hemoptysis or weight loss greater than 15 lbs.]***?** ☐ No ☐ Yes

*If yes, please explain____

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. This risk assessment tool will help the radiologist interpret your examination. Please check the appropriate box.

***Smoking History:** ☐ Smoker ☐ Former Smoker

*Please specify the last year you smoked ______________

***Former smokers,** if you quit more than 15 years ago have you had **any** cigarettes during your quit period?

No ☐ Yes ☐

***For both current and former smokers, on <u>average</u> how many packs a day do you smoke(d)?**

☐1/2 pk/ day ☐3/4 pk/ day ☐1 pk/ day ☐2 pk/ day

Age at first cigarette _________ Age at last cigarette _________ = **Total:** ____________

4. Have you been diagnosed with any other form of cancer in the last 5 years? *[Patient should not be under active cancer treatment]* ☐ No ☐ Yes

*If so, please specify which type _________

*Check the form of treatment: ☐ Surgery ☐ Radiation ☐ 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? ☐ No ☐ Yes

*If yes, please specify Relation________________ Age at diagnosis_________ Died of cancer ☐ No ☐ Yes

Relation________________ Age at diagnosis_________ Died of cancer ☐ No ☐ Yes

7. Have you been exposed to second hand smoke exposure, if so:specify ☐ No ☐ Yes

☐ 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]? ☐ No ☐ 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: ____Date: ________ Time: ________

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: ________