DIAGNOSTIC IMAGING CENTERS, P.A.

CT Chest Low Dose Screening

Patient Information

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Weight: _____

Height: _____ Physician: _____

❑Male ❑Female

Medical Information

1. Are you 55 -77 years of age? ❑Yes ❑No
2. Have you smoked at least 1 pack of cigarettes per day for 30+ years (or 2 packs per day for 15 years)? ❑Yes ❑No
3. Are you a current smoker or quit within the past 15 years? ❑Yes ❑No
   - If former smoker, how many years since you quit smoking? _____ years
4. Are you symptom free (no history of lung cancer, coughing up blood, unexplained weight loss, etc)? ❑Yes ❑No
5. Give name and location of any previous chest CT: _____

I acknowledge that smoking cessation literature was made available to me by Diagnostic Imaging Centers, P.A.

I authorize Diagnostic Imaging Centers, P.A. to mail the results of this exam to the following address:

Street_____

City_____**State**_____ **Zip**_____

Patient signature_____ **Technologist signature**_____

For Female Patients Only

1. Date of last menstrual period: _____ Post Menopausal? ❑Yes ❑No
2. Are you pregnant or experiencing a late menstrual period? ❑Yes ❑No
3. Hysterectomy: ❑Yes ❑No
   If yes, give date: _____
4. Are you taking oral contraceptives or receiving hormonal treatment? ❑Yes ❑No

Patient signature: _____