CEDARS-SINAI®

S. MARK TAPER FOUNDATION IMAGING CENTER

CT WHOLE BODY SCREENING QUESTIONNAIRE

PATIENT I.D.

Name: _____

Birthday: _____ Age: _____

Attending Physician: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Physician's Phone: _____ Fax: _____

Do you have an Occupational Exposure History *(e.g. asbestos, chemicals, fumes, etc.)*

❑ No ❑ Yes, *please explain*: _____

Do you have a Smoking History?

❑ None ❑ Former smoker, stopped smoking in year _____ packs / day _____

❑ Current smoker, packs / day _____

Do you have family history of cancer?

❑ None ❑ Yes, *please explain*: _____

Do you have personal history of cancer?

❑ None ❑ Yes, *please explain*: _____

Do you have any symptoms in the chest area?

❑ None ❑ Yes, *please explain*: _____

Do you have any symptoms in the abdomen area?

❑ None ❑ Yes, *please explain*: _____

Have you experienced recent weight loss?

❑ None ❑ Yes, *please explain*: _____

Additional Patient Comments _____

_____

_____

_____

_____

NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF STAFF (please print)	**SIGNATURE OF STAFF**	**DATE**	**TIME**