

CT WHOLE BODY SCREENING QUESTIONNAIRE

PATIENT I.D.

Name:			
Birthday: Age:			
Attending Physician:			
Physician's Address:			
City:			
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	ТІМЕ
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NAME OF STAFF (please print)	SIGNATURE OF STAFF	DATE	TIME