CEDARS-SINAI®

S. MARK TAPER FOUNDATION
IMAGING CENTER

LUNG VQ SCAN QUESTIONNAIRE

PATIENT I.D.

1. **Please describe your symptoms:**

Shortness of breath	❑ Yes	❑ No
Chest pain / discomfort	❑ Yes	❑ No
Cough	❑ Yes	❑ No

Other *(specify)*: ___________________________________

If you answered yes to symptoms please answer a) – c) Otherwise proceed to question 2.

a. *Details of shortness of breath*
- ❑ Recent onset
- ❑ Recent worsening
- ❑ At rest
- ❑ With exertion walking on flat
- ❑ With exertion running / climbing stairs

b. *Details of chest pain*
- ❑ Recent onset
- ❑ Recent worsening
- ❑ At rest
- ❑ With breathing
- ❑ With coughing

c. *Details of cough*
- ❑ Dry
- ❑ Productive
- ❑ Blood stained

2. **Any recent prolonged period of bed rest or travel?** ❑ Yes ❑ No

3. **Any recent leg or arm injury or surgery?** ❑ Yes ❑ No

4. **Do you have lung disease?** (*Check all that apply)*
- ❑ Asthma
- ❑ Chronic bronchitis or emphysema or COPD
- ❑ Bronchiectasis
- ❑ Lung cancer
- ❑ Other *(please specify)* ______________________________________

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5. **Do you smoke?** ❑ Yes ❑ No
   If yes, how many packs per day / week? ____________________
   How long have you smoked? ____________________
   If you recently quit, when was the last time you smoked? ______________________________

6. **Have you ever had a Pulmonary Embolus (PE)?** ❑ Yes ❑ No

7. **Have you ever had DVT *(deep venous thrombus, clot in leg)*?** ❑ Yes ❑ No

8. **Have you ever had any previous surgery to the lungs?** ❑ Yes ❑ No

9. **Have you ever had any prior history of cancer?** ❑ Yes ❑ No

10. **Have you ever had any prior history of blood clot problems?** ❑ Yes ❑ No

11. **Are you currently using any birth control pills?** ❑ Yes ❑ No

[Dose label #1 here] [Dose label #2 here]

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