



Lung Screening Questionnaire

To learn more about our patients and to better evaluate this screening, please answer the following questions, read the statement and sign below.

Name: _____ Date of Birth: _____

	Yes	No
Do you have a family or personal history of Lung Cancer?	_____	_____
Do you smoke, or are you exposed to second-hand smoke?	_____	_____ yrs _____
Have you ever been diagnosed with high cholesterol?	_____	_____
Have you ever been diagnosed with high blood pressure or hypertension?	_____	_____
Do you have a cough or congestion?	_____	_____ yrs _____
Have you ever been diagnosed with a chronic Lung disease or COPD ?	_____	_____ yrs _____
Do you have uncomfortable chest pain, fullness, pressure or squeezing?	_____	_____ yrs _____
Do you ever feel pain spreading to the shoulders neck or arms?	_____	_____
Have you had chest discomfort with lightheadedness, fainting, sweating, nausea or shortness of breath?	_____	_____

This test is used to detect lung cancers at earlier, more curable stages for people who are at greater risk.

Patient Signature

Date