Patient Information		
Last Name:	First:	Middle:
Date of Birth:		
Referring Physician:		

Physical Details		
Gender: ☐ Male ☐ Female	Height: _____________ ft./in.	Weight: ____________ LBS

If you have/had cancer, indicate your age at diagnosis:

Cancer Type	At Age
Bladder	
Breast	
Cervical	
Colorectal	
Endometrial	
Esophageal	
Head & Neck	
Kidney	
Lung	
Lymphoma	
Ovarian	
Pancreatic	
Prostate	
Stomach	
Other:______________	

Check box for condition(s) you have:

☐ Pulmonary Fibrosis ☐ Chronic Bronchitis Emphysema
☐ Coronary Artery Disease ☐ Tuberculosis ☐ COPD
☐ Congestive Heart Failure ☐ Peripheral Vascular Disease

Check box of substance(s) you've been exposed to:

☐ Arsenic ☐ Asbestos ☐ Beryllium ☐ Cadmium
☐ Chromium ☐ Coal Smoke ☐ Diesel Fumes
☐ Nickel ☐ Silica ☐ Soot

Have you had exposure to radon? ☐ Yes ☐ No

If yes, how? ☐ Documented Residential ☐ Firefighter
☐ Military—Active Combat ☐ Mining

Do you have a family history of lung cancer? ☐ Yes ☐ No ☐ Unknown

If Yes: ☐ Mother ☐ Father ☐ Brother/Sister Other:_______________

____ ____________ ____________

Patient/Representative Signature Date Time

Print Representative Name:__________________ Relationship to Patient:__________________

STAFF USE ONLY

Medical Record Number:____________________ Smoking Status: See Provider's Order

Reason for Exam/Indicated Problems:

____

CT Scanner Manufacturer: ☐ Siemens ☐ Philips CT Scanner Model: _________________

CTDIvol (mGy):______________ DLP (mGy*cm): _______________ Tube Current-Time (mAs):______________

Tube Voltage (kV):______________ Scanning Time(s):________________ Scanning Volume (cm): ___________

Pitch: _______________

Reconstructed image width (nominal width of reconstructed image along z-axis) (mm): _______________________

Tech Signature:____ Date:_____________ Time:_____________

Low-Dose Computed Tomography (LDCT) History Record

MNM 721.299

4/7/2020