Follow-Up Form

Follow-up Date (DD/Mmm/YYYY)

Date of Baseline CT (DD/Mmm/YYYY)

Time Since Baseline (Months)

Coordinator

Ordering Practitioner Name

Ordering Practitioner NPI

Is this an annual CT scan? ○ no ○ yes

During the past year, have you experienced any of the symptoms listed below? ○ **no** ○ **yes (check all that apply)**

☐ worsening of cough, ☐ cough producing bloody material, ☐ persistent hoarseness, ☐ unexplained weight loss

If yes, have you seen a physician for this? ○ no ○ yes **Whom?**

If yes, are you now experiencing them? ○ no ○ yes

Have you taken antibiotics since your last CT scan? ○ no ○ yes **If so, when?** (Mmm/YYYY)

When did you most recently have a chest X-ray? -

If so, where was the test done?

When did you most recently have a chest CT? -

If so, where was the test done?

Have you been hospitalized or had surgery in the past year? ○ no ○ yes

If yes, for what?

When? (Mmm/YYYY)

Where?

Have you had a diagnosis of cancer in the past year? ○ no ○ yes

If yes, what part of body? -

Other (specify)

When were you diagnosed? (Mmm/YYYY)

If lung cancer has been diagnosed, have you had surgery? ○ no ○ yes

When? (DD/Mmm/YYYY)

Where?

If a lung cancer has been removed, is there evidence of recurrence? ○ no ○ yes

If yes, describe:

Smoking

Over the past month, have you smoked cigarettes at all, even a puff? ○ no ○ yes ○ never smoked

If yes, on average, on how many days per week are you currently smoking cigarettes?

On average, on the days that you are smoking cigarettes, how many packs of cigarettes are you currently smoking per day (PPD)?

If no, when was the date of your last cigarette (DD/Mmm/YYYY)? - -

Did you participate in any smoking cessation program during the past year? ○ no ○ yes ○ I did not want to participate

Smoking cessation information or counselling was offered to the patient ○ no ○ yes

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