

Background Form ?

Visit date ?
(DD/Mmm/YYYY)

Date of Birth (DD/Mmm/YYYY)

Occupation ?
(If retired, also indicate previous occupation)

Sex ☐ M ☐ F

Ethnicity

Level of Education

Age

Occupation Code ?

Height ?

☐ in
☐ cm

Weight

☐ lbs
☐ kg

BMI ?

Race ?

Other (specify)

Served in the military? ☐ no ☐ yes. If yes, what branch:

Ordering Information

Ordering information is **required** for all patients undergoing a screening exam using the G0297 code.

Was a CT lung screening scan ordered for this patient (CPT code G0297)? ☐ no ☐ yes

(if no, the rest of the questions in this section are optional)

Ordering Practitioner First Name

Last name

NPI

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Documentation of shared decision making

☐ no ☐ yes (shared decision making is required for reimbursement for G0297 exams on baseline **only**)

Ordering practitioner reported smoking status:

☐ current ☐ former

Ordering practitioner reported pack years

Ordering practitioner reported years since quit

(only required for former smokers)

Ordering practitioner reported asymptomatic for lung cancer:

☐ no ☐ yes

Clinical information

(information will be copied to CT report)

Medical Conditions ?

Family history of lung cancer?

☐ no ☐ yes ☐ ?

Father? ☐ no ☐ yes
Mother? ☐ no ☐ yes
Siblings? ☐ no ☐ yes

Any Cancer

☐ no ☐ yes ☐ ?

When? (YYYY)

Primary site?

Asthma

☐ no ☐ yes ☐ ?

Under current treatment? ☐ no ☐ yes

Emphysema or Chronic Bronchitis(COPD)?

☐ no ☐ yes ☐ ?

When? (YYYY)

High Blood Pressure

☐ no ☐ yes ☐ ?

Treated? ☐ no ☐ yes

Since When? (YYYY)

Highest Value?

High Cholesterol

☐ no ☐ yes ☐ ?

Treated? ☐ no ☐ yes

Had an angioplasty or Stent?

☐ no ☐ yes ☐ ?

When? (YYYY)

Where treated?

MI

☐ no ☐ yes ☐ ?

When? (YYYY)

Where treated?

Stroke

☐ no ☐ yes ☐ ?

When? (YYYY)

Where treated?

Peripheral Vascular Disease (Poor Circulation)

☐ no ☐ yes ☐ ?

Diabetes

☐ no ☐ yes ☐ ?

Starting at what age?

Treated? ☐ no ☐ yes

Liver Disease

☐ no ☐ yes ☐ ?

☐ Mild ☐ Moderate/Severe

Kidney (Renal) Disease

☐ no ☐ yes ☐ ?

☐ Mild ☐ Moderate/Severe

Have you experienced any symptoms indicative of lung cancer? ? ☐ no ☐ yes (check all that apply)

- ☐ cough producing bloody material
☐ unexplained weight loss greater than 20 lbs.
☐ unexplained hoarseness,

☐ other (specify)

When did you most recently have a chest CT? -

If so, where was the test done?

Pulmonary Function Test Data



Have you had a pulmonary function test within the last five years? ☐ no ☐ yes

(Values are not required)

FEV1 (L/s)

FVC (L)

FEV1/FVC (%)

Diffusion Capacity (mL/min/mm Hg)

Occupational Exposure

To your knowledge, have you been exposed to asbestos?


☐ no ☐ yes

☐ asbestos product manufacturing ☐ auto repair

☐ building maintenance ☐ chemical industry/foundry/refinery

☐ construction/demolition ☐ mining ☐ nuclear industry

☐ ship construction/repair ☐ other (e.g. clean up, toxic waste, chemical/radiation exposure)

Have you ever worked in any of the following?

If other, specify

Tobacco Use

Have you smoked at least 100 cigarettes in your lifetime? (100 cigarettes = 5 packs)


☐ no ☐ yes
If no, were you exposed to secondhand smoke? ☐ no ☐ yes

If yes, skip to the "Secondhand Tobacco Smoke Exposure" section.

About how old were you when you first started smoking cigarettes regularly?

Over the past month, have you smoked at all, even one cigarette?


☐ no ☐ yes

If yes, skip to "Current Cigarette Smoker".

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



If no, number of years since quit (computed from quit date):

Former Cigarette Smoker



When you were a smoker, on approximately how many days per week did you smoke cigarettes?

On the days that you did smoke, approximately how many packs of cigarettes did you smoke per day (PPD)?



For approximately how many years did you smoke this amount?



Current Cigarette Smoker



On average, on how many days per week do you (or did you) smoke cigarettes?

On average, how many packs of cigarettes do you (or did you) smoke per day (PPD)?



For approximately how many years have you smoked this amount?



Have you ever tried to quit smoking?


☐ no ☐ yes

If yes, how many times?

In the last 12 months, how many times have you quit smoking for at least 24 hours?



Are you seriously thinking of quitting smoking?



Smoking cessation information or counselling was offered to subject


☐ no ☐ yes

packs/day (PPD)	Total Pack-Years
1 cig / day = 0.05	<input type="text"/>
2-3 cig / day = 0.10	
4 cig / day = 0.20	
5 cig / day = 0.25	
10 cig / day = 0.50	
15 cig / day = 0.75	
20 cig / day = 1.00	

Secondhand Tobacco Smoke Exposure / Occupation

After age 18, did you work for more than one year in a worksite where smoking was allowed? ☐ no ☐ yesDid you ever work for more than one year in a job where you were exposed to other people's tobacco smoke? ☐ no ☐ yes

Age Range (from Most Recent)	Job	Smoking
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere

Secondhand Tobacco Smoke Exposure / Household

- Did anyone in your house smoke in the home when you were under 18? ☐ no ☐ yes
- Was smoking allowed inside the house? ☐ not permitted ☐ restricted ☐ allowed anywhere
- Did your mother/primary care giver smoke when you were under age 7? ☐ no ☐ yes
- Did your mother/primary care giver smoke when you were ages 7-18? ☐ no ☐ yes
- Did anyone else beside your mother/primary care giver smoke in the home when you were under 18? ☐ no ☐ yes
- Do you currently live with a smoker? ☐ no ☐ yes
- After age 18, did you live with someone for more than one year who smoked in your presence? ☐ no ☐ yes
- If yes, at what ages did you live with someone who smoked around you and how much did they smoke? (Most Recent First)

Age Range	Amount	Smoking
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere
<input type="text"/>	<input type="text"/>	<input type="radio"/> not permitted <input type="radio"/> restricted <input type="radio"/> allowed anywhere

Your Health in General

1. Overall, how would you rate your health during the **past 4 weeks**?
- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Excellent | Very good | Good | Fair | Poor | Very Poor |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
2. During the **past 4 weeks**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|----------------------------------|
| Not at all | Very little | Somewhat | Quite a lot | Could not do physical activities |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
3. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------|
| None at all | A little bit | Some | Quite a lot | Could not do daily work |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
4. How much **bodily** pain have you had during the **past 4 weeks**?
- | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| None | Very mild | Mild | Moderate | Severe | Very Severe |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
5. During the **past 4 weeks**, how much energy did you have?
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Very much | Quite a lot | Some | A little | None |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
6. During the **past 4 weeks**, how much did your physical health or emotional problems limit your usual social activities with family or friends?
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|--------------------------------|
| None at all | Very little | Somewhat | Quite a lot | Could not do social activities |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
7. During the **past 4 weeks**, how much have you been bothered by **emotional problems** (such as feeling anxious, depressed or irritable)?
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Not at all | Slightly | Moderately | Quite a lot | Extremely |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
8. During the **past 4 weeks**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?
- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------------|
| Not at all | Very little | Somewhat | Quite a lot | Could not do daily activities |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |