Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

OFFICE USE ONLY
Name:
MRN:
Date of birth:

LUNG HEALTH QUESTIONNAIRE

DIRECTIONS:
Please complete the following form prior to your visit. If you have any questions, please call the lung screening program staff at 646-962-5864 (LUNG). You and your referring physician will automatically receive your lung imaging results. If you would like results sent to additional providers, please complete an additional records request form.

DEMOGRAPHICS:

Name: _____ Date of Birth: _____

Preferred phone number: _____ Email: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Are you pregnant: ☐ Yes ☐ No Last menstrual cycle: _____ ☐ Not applicable

Do you have a known allergy to Latex? ☐ Yes ☐ No

If yes, please provide details (allergies and reactions): _____

Is this your initial lung screening exam? ☐ Yes ☐ No

If no, what was the date and location of your most recent CT scan? _____

Have you had a CT of your chest in the past year? ☐ Yes ☐ No

If yes, please provide details: _____

Are you experiencing any of the below? ☐ New or Worsening Cough ☐ Coughing up blood

☐ Unexpected weight loss of 10 pounds or more in the past 3 month

If any of the above are selected, please discuss your symptoms with your Primary Care Provider

Have you ever received a Covid-19 vaccine? ☐ Yes ☐ No

If yes, what is the approximate date of your most recent Covid-19 vaccine? _____

Did you receive the vaccine in your left arm or right arm? _____

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Please indicate your cigarette smoking status (select one): ☐ Never ☐ Former ☐ Current
Approximate Start Age: _____ ☐ Not applicable
Approximate Quit Age: _____ ☐ Not applicable
Approximate total number of years you smoked: _____
Throughout your smoking history, on average, how many cigarettes did you smoke per day?
(Note: 1 pack = 20 cigarettes) _____ ☐ Not applicable

How did you hear about our Lung Screen Program?
☐ NYP Provider ☐ Outside Provider ☐ Website ☐ Social Media ☐ Community Event ☐ Advertisement
☐ Other: _____

QUESTIONNAIRE COMPLETED BY:

Print Name: _____ Signature: _____ Date: _____

OFFICE USE ONLY:
Questionnaire reviewed by:

Print Name: _____ Signature: _____ Date: _____

Notes: _____
_____
_____
_____
_____
_____
_____

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646-697-LUNG (5864) · 212-746-7664 (Fax) · radconsult@med.cornell.edu · cornell-lungscreen.com

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