

Lung Cancer Screening History Assessment



PLEASE PRINT CLEARLY

Name (Last) (First) (MI)			Date of Birth / /	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone		Work Phone		Cell Phone	
Mailing Address					
Primary Care Doctor - FIRST & LAST Name		Street Address		City	State Zip
If you would like a copy of your results sent to a pulmonologist, please write FIRST & LAST Name and address					
If you would like a copy of your results sent to a cardiologist, please write FIRST & LAST Name and address					
Occupation		How did you hear about lung cancer screening?		Email Address	
Years of Education <input type="checkbox"/> <12 <input type="checkbox"/> 12 (or GED) <input type="checkbox"/> 2 yr college/trade school <input type="checkbox"/> Undergraduate <input type="checkbox"/> Advanced degree				Served in the military? (If yes, what branch?): <input type="checkbox"/> No <input type="checkbox"/> Yes	
Race/Ethnicity		<input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other	

WHAT YOU NEED TO KNOW Please read below and sign

Lung cancer screening is not a one time exam, but a process that involves periodic follow-up CT exams over time to look for newly emerging cancer. This test can detect tiny nodules in the lungs that are too small to be seen on a chest x-ray. The capability of CT scanners to detect these tiny nodules and to compare for changes in size over time is critical to the screening process. Research shows low-dose CT screening is effective in reducing lung cancer deaths.

Like most medical procedures, screening has inherent risks and limitations. Considering the lifetime probability of developing lung cancer is 1 in 14 people, and the 5 year late-stage survival rate is 1-5%, the risks of screening through an organized screening program are minimal compared to the benefits of early detection. The risks and limitations of screening include: **This test may find abnormalities that have to be evaluated with more tests.** Finding abnormalities can lead to additional tests and cause anxiety. Tests could include repeat CT scans or more invasive procedures such as a bronchoscopy or biopsy. Some invasive procedures can lead to complications like a collapsed lung or, rarely, even death. **This test uses a low-dose of radiation.** This test will expose you to less than 1.5 millisieverts (mSv) of radiation. This is much less radiation than a conventional chest CT scan, which would expose you to about 7 - 10 mSv. Evidence suggests that the risk of cancer caused by this test is very low. Harm can come in the form of improperly performed CT scans that inappropriately expose patients to much higher than necessary levels of radiation - another reason why CT screening should only be done at a competent, experienced site that adheres to a well-defined protocol for screening. **This test may not detect all lung cancers and can't guarantee early detection will avoid death.** Lung cancer found early increases your chance for survival through early treatment and cure; however, some cancers can recur, even when found early, and spread to other parts of the body. This is called metastasis. Once a cancer has spread, it is difficult to treat and often leads to death. Research continues to show early detection is the best hope for survival.

As part of the lung cancer screening process, a multi-disciplinary review by our Lung Cancer Screening Physician Team is recommended. Your signature below indicates you authorize this team of doctors with special training and expertise in lung cancer screening to review your exam and make recommendations following an established screening protocol. These physicians are committed to following best published practices to avoid over-treatment and unnecessary invasive procedures.

I acknowledge, understand and agree that my CT examination report will be mailed to me and my primary physician listed above. The report may contain information that is protected under State law and Federal regulations and that WellStar Health System is not liable or responsible should the report and/or images be lost in the United States mail. It is my responsibility to follow up with my doctor regarding the results of this exam. I have been given a copy of the Lung Cancer Screening Patient Information Guide and all questions I have regarding this examination have been adequately answered.

Signature:

Date:

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HEALTH & BACKGROUND HISTORY			
Is this your first lung cancer screening exam? <input type="checkbox"/> No <input type="checkbox"/> Yes	Have you taken any antibiotics within the past 6 months? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____ For What? _____		
Are you currently experiencing any of the following symptoms: worsening cough, coughing up blood, persistent hoarseness or unexplained weight loss?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please explain	
Do you have a family history of lung cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please list family member(s)	
Do you have any known exposure to radon, asbestos or other cancer causing or concerning substance?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, please explain	
Have you worked in any of these industries: auto repair, chemical, foundry, refinery, building maintenance, mining, construction, demolition, nuclear power, asbestos product manufacturing, or ship construction/repair? <input type="checkbox"/> No <input type="checkbox"/> Yes			If yes, please explain
Please list any neck, back, abdominal or chest surgeries:			
Have you been diagnosed or had any of the following?			
<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	Type?	Diagnosed when?
<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma		
<input type="checkbox"/> No <input type="checkbox"/> Yes	Emphysema or COPD		
<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure		
<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol		
<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes		
<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Attack, Angioplasty, Heart Stent or Heart Surgery		
TOBACCO USE & SMOKING EXPOSURE			
Please check one: <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker (smoked less than 100 cigarettes in your lifetime) If never smoker, how many years were you exposed to secondhand smoke? _____			
How old were you when you first started smoking?	Which tobacco products would you regularly use - <i>either in the past or now?</i> <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipes <input type="checkbox"/> Cigars <input type="checkbox"/> Other		
How many packs of cigarettes do you now or used to smoke per day? If pipe, # of loads _____ # of Cigars _____ Other _____			
How many years have you or did you smoke?	Have you since quit, if so, when? <input type="checkbox"/> No <input type="checkbox"/> Yes _____	Are you currently trying to quit smoking? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, would you like to receive a Quit Smoking Support Kit that contains information and resources to help you stop smoking? <input type="checkbox"/> No <input type="checkbox"/> Yes - Kit will be sent to you with your screening results		Research Opportunity: <input type="checkbox"/> Yes, I have received a copy of the Research Registry Information Sheet and agree to participate. I understand that I may withdraw my participation at any time.	

WELLSTAR STAFF USE – IMPORTANT: Please remember!

- 1) Give screening participant **PATIENT INFORMATION GUIDE** and instructions to call the Program Coordinator with any questions.
- 2) Fax this form along with Check-In document to 678-594-4315
- 3) Call the Program Coordinator if you have any questions at 678-594-4302 or 770-312-3482