TRI-CITY RADIOLOGY

CT CHEST "LUNG SCREENING" Evaluation Form

The following information is necessary to comply with the federally mandated ICD-10 billing requirements, which takes effective Oct. 1st 2015.

NAME:_____ **Age:**_____ **Weight:**_____ **Date:** _____

1. What was your chief complaint when you visited your doctor? _____

   _____

2. Do you currently smoke? **YES / NO**

   How many years? _____

   Average amount of cigarettes per day? _____

3. **Are you currently experiencing?**

   a. weight loss? **YES** or **NO**

   b. fever? **YES** or **NO**

   c. bloody cough? **YES** or **NO**

   d. increasing shortness of breath? **YES** or **NO**

   e. chest pain? **YES** or **NO**

   f. Have you had a respiratory infection in the last 12 weeks? **YES** or **NO**

   g. Are you on supplemental oxygen? **YES** or **NO**

   h. Any other symptoms that are associated with your chest? **YES** or **NO**

4. Any **prior surgeries** on your **chest**? **YES** or **NO**

   Please describe in detail, when and where your surgery was performed? _____

   _____

5. Do you have a history of **cancer**? If yes, please list:

   a. Type(s) of cancer: _____

   b. Diagnosis date(s): _____

   c. Treatments you have completed for it (radiation, chemotherapy): _____

   _____

6. Have you had any other imaging tests done on the body part we are imaging today? **YES** or **NO**

   X-Rays? _____ When & Where? _____

   CT Scan? _____ When & Where? _____

   MRI Scan? _____ When & Where? _____

   Bone Scan? _____ When & Where? _____

   Ultrasound? _____ When & Where? _____

Female Patients Only:

Are you pregnant? **YES** or **NO** If no, please give the date of your LMP: _____