UCLA Health

LUNG QUESTIONNAIRE
UCLA RADIOLOGY

MRN:
Patient Name:

(Patient Label)

Directions: This survey gives your doctors information about conditions that may affect your lung health or risk of cancer. Please answer questions by darkening the appropriate squares with a blue/black ink pen and print clearly in UPPERCASE letters.	**OFFICE USE ONLY** **Accession Number** ☐☐☐☐☐☐☐☐

A. DEMOGRAPHIC INFORMATION	
Age	☐☐ years old **Weight** ☐☐☐ lbs **Height** ☐ ft ☐☐ in
Sex	☐ Male ☐ Female
Race	☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ More than one race ☐ American Indian/Alaska native ☐ Unknown/Prefer not to answer
Ethnicity	☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown/Prefer not to Answer
Education	☐ Less than high school graduate ☐ College graduate ☐ High school graduate or GED ☐ Some college or technical school ☐ Some training after high school ☐ Postgraduate ☐ Unknown/Prefer not to answer
Marital status	☐ Never married ☐ Divorced ☐ Married or living as married ☐ Other ☐ Widowed ☐ Unknown/Prefer not to answer ☐ Separated

B. SIGNS OR SYMPTOMS: Please indicate whether you have had any of the following <u>NOW or in the last 2 months</u>:

☐ I have **NO SIGNS OR SYMPTOMS**

☐ Blood in sputum ☐ Persisting headache ☐ Shortness of breath

☐ Chest pain ☐ New/Changing cough ☐ Hoarseness/Change in voice

☐ Fatigue/Weakness ☐ Loss of appetite ☐ Unexpected weight loss over 10 pounds

☐ Fevers/Chills ☐ Wheezing

UCLA Health

LUNG QUESTIONNAIRE
UCLA RADIOLOGY

MRN:
Patient Name:

(Patient Label)

C. CIGARETTE SMOKING HISTORY	
1. Describe your present cigarette smoking status.	☐ Never smoker (less than 100 cigarettes in my life) ☐ Prior smoker (quit more than 1 month ago) ☐ Current smoker (at least 1 cigarette daily)
2. Is there now or has there ever been a smoker in your household?	☐ NO ☐ YES ☐ UNKNOWN

If you indicated that you <u>currently or previously smoked cigarettes</u>, please answer the following. Otherwise, skip to D.	
3. At what age did you regularly start smoking cigarettes (smoking at least once a day)?	☐☐ years old
4. For how many years have/did you smoke regularly (at least 1 cigarette daily)?	☐☐ years
5. Over the entire time that you have smoked, what is the *average* number of cigarettes you smoke/did smoke per day?	☐☐☐ cigarettes/day
6. Over the entire time that you have smoked, what is the *highest* number of cigarettes you smoke/did smoke per day?	☐☐☐ cigarettes/day
7. If you no longer smoke, at what age did you quit smoking?	☐☐ years old

D. Have you lived or worked for <u>1 or more years</u> near any of the following occupations or environments? Please answer YES, NO, or NOT SURE for each.	**NO**	**YES**	**NOT SURE**
Exposure to Radon	☐	☐	☐
Working with or around asbestos	☐	☐	☐
Working with or around cadmium	☐	☐	☐
Working with or around silica, arsenic, beryllium, chromium, diesel fumes, or nickel	☐	☐	☐

E. Have you ever had any of the following? Please answer YES, NO, or NOT SURE for each.	**NO**	**YES**	**NOT SURE**
History of an abnormal chest x-ray or other chest image?	☐	☐	☐
History of a lung nodule?	☐	☐	☐
History of abnormal pulmonary function test?	☐	☐	☐
History of pneumonia?	☐	☐	☐

UCLA Health

LUNG QUESTIONNAIRE
UCLA RADIOLOGY

MRN:
Patient Name:

(Patient Label)

F. LUNG CANCER HISTORY			
1. Has a doctor ever told you that you have lung cancer?	☐ NO	☐ YES	☐ NOT SURE
If you indicated YES in the previous question, please answer the following. Otherwise, skip to Section G.			
2. Which lung was involved?	☐ RIGHT	☐ LEFT	☐ BOTH lungs
3. Have you undergone SURGERY to remove lung cancer?	☐ NO	☐ YES	☐ NOT SURE
4. Have you undergone CHEMOTHERAPY for lung cancer?	☐ NO	☐ YES	☐ NOT SURE
5. Have you undergone RADIATION THERAPY for lung cancer?	☐ NO	☐ YES	☐ NOT SURE
6. Have you undergone OTHER THERAPY for lung cancer?	☐ NO	☐ YES	☐ NOT SURE

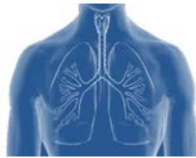
G. Have any of the following *direct blood relatives* ever been diagnosed with *lung cancer*? Include half-siblings.

Relative	No	Yes	Was the diagnosis made at or before age 60? Mark if YES	How Many?		
				1	2	3 or more
Father	☐	☐	☐			
Mother	☐	☐	☐			
Sibling(s)	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐
Maternal Grandparent(s)	☐	☐	☐	☐	☐	☐
Paternal Grandparent(s)	☐	☐	☐	☐	☐	☐

H. OTHER CANCERS: Please indicate whether you have previously been diagnosed with other cancers. Fill in all that apply.

☐ Bladder	☐ Head / Neck (mouth, nose, throat)	☐ Pancreas
☐ Breast	☐ Kidney	☐ Prostate
☐ Cervix	☐ Liver	☐ Skin (Melanoma only)
☐ Colon / Rectum	☐ Lymphoma / Hodgkin's	☐ Thyroid
☐ Esophagus	☐ Mesothelioma	☐ Uterus, endometrium
☐ Gall bladder	☐ Ovary	☐ **NO PRIOR CANCERS**

UCLA Health



LUNG QUESTIONNAIRE
UCLA RADIOLOGY

MRN:
Patient Name:

(Patient Label)

I. Have *any relatives* ever been diagnosed with the following?

- ☐ Lung Cancer
- ☐ Bladder Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Esophageal Cancer
- ☐ Head / Neck Cancer
- ☐ Stomach Cancer
- ☐ Emphysema or COPD

J. OTHER MEDICAL CONDITIONS: Check all medical conditions you have EVER been diagnosed with by a PHYSICIAN. Fill in all that apply.

☐ Angina / Heart attack	☐ HIV or AIDS
☐ Asthma	☐ Kidney problem
☐ Bronchiectasis	☐ Mild liver disease
☐ Chronic bronchitis	☐ Moderate or severe liver disease
☐ Coccidioidomycosis / Valley Fever	☐ Myocardial Infarction
☐ Collagen vascular disease	☐ Peptic ulcer disease
☐ Congestive heart disease	☐ Peripheral vascular disease
☐ Connective tissue disease	☐ Pneumonia
☐ Coronary artery disease	☐ Pulmonary embolism
☐ COPD	☐ Pulmonary fibrosis
☐ Emphysema	☐ Pulmonary artery hypertension
☐ Diabetes	☐ Require supplemental oxygen
☐ Gastro-esophageal reflux	☐ Sarcoidosis
☐ Hemiplegia / Paraplegia	☐ Seizures
☐ High blood pressure/Hypertension	☐ Stroke / Cerebrovascular disease
☐ Histoplasmosis/Granulomatosis	☐ Tuberculosis
☐ I have **NO OTHER MEDICAL CONDITIONS**	

Patient Signature:________________________________ Date:__________ Time:___________

If signed by anyone other than the patient, please state your relation to the patient:_____________

Interpreter Signature:_____________________________ Date:__________ Time:___________

Interpreter ID #: ___________________