Advanced Medical Imaging
Bozeman Deaconess Hospital & Intercity Radiology

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LOW DOSE CHEST CT - SCREENING QUESTIONAIRE

Name: _____ Date of Birth: _____

Referring Physician:_____

_____I am aware this screening exam is $400.00 and is not covered by insurance. I agree to pay for this exam at the time of service.

Have you had a previous CT of the Chest or Chest X-ray? Yes_____ No_____

If yes, where was it performed?_____

Do you currently have lung cancer? Yes_____ No_____

Smoking History: Current smoker? _____ Past smoker? _____(how many years since you quit smoking?_____)

How many packs do you / did you smoke in a day? _____

How many years have you smoked / did you smoke? _____

*Your pack-year total must be 30 to qualify for a screening Low Dose Chest CT. Your pack-year total is determined by the number of packs per day multiplied by the number of years smoked.

Signature of Patient: _____ Date: _____