Advanced Medical Imaging
Bozeman Health & Intercity Radiology

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LOW DOSE CHEST CT - SCREENING QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height:_____ Weight:_____

Referring Physician:_____

_____I am aware the cost of this screening exam is $400.00. My insurance company may or may not cover this exam. If my insurance carrier were to deny payment, I understand I will be responsible for payment.

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: _____