LUNG CANCER
SCREENING FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : D D M M Y Y

Gender : Male Female

E-Mail :

Phone Number :

SMOKING HISTORY AND EXPOSURE

Do you have a history of smoking? Yes No

If yes, please specify:

Number of cigarettes smoked per day:

Duration of smoking:

Have you quit smoking? Yes No

If yes, please specify the duration of quitting:

Have you lived with someone who smoked regularly for years? Yes No

Any history of exposure to chemicals like asbestos, radon? Yes No

SYMPTOMS AND HEALTH HISTORY

Have you experienced any persistent cough, wheezing, or chest pain? Yes No

Do you have a history of respiratory illnesses or lung diseases? Yes No

Any unexplained weight loss or fatigue? Yes No

GENERAL HEALTH AND LIFESTYLE

Overall Health Status: Excellent Very Good Good Fair Poor

Physical Activity Level: Sedentary Lightly Active Moderately Active Very Active

Dietary Habits: Balanced and Healthy High in Processed Foods Vegetarian/Vegan Other (please specify): _____

THANK YOU FOR YOUR INFORMATION