UAB Imaging Screening Center
Participant Questionnaire

Section 1:
Please complete all of the questions in this section. Please note that some questions are repeated in some sections of this questionnaire and you only need to answer them once.

DATE: ___________ UAB Medical Record Number (if known): ______________________

NAME: ___________________ DATE OF BIRTH: __________ PHONE #: ______________

ADDRESS: ________________________________________________________________

________________________________________________________________________

Gender:         ☐ Male ☐ Female
Race:           ☐ White ☐ African-American ☐ Asian ☐ Hispanic ☐ Other

Do you have a personal physician? ☐ No ☐ Yes
If yes: Physician Name: _________________________ Physician Phone # (if known): _____________

Location or name of practice ____________________________________________________

Patient History

Are you pregnant? ☐ No ☐ Yes

Do you have any major health conditions or problems? ☐ No ☐ Yes
If yes, please specify __________________________________________________________

Section 2:
Please complete Section 2 below ONLY if you would like to have the screening examination of the HEART or for AAA. Otherwise, skip to Section 3.

Patient History

Has a doctor ever told you that you have the following conditions:
Heart attack (myocardial infarction, coronary occlusion, coronary thrombosis) ☐ No ☐ Yes
Angina ☐ No ☐ Yes
Heart failure (congestive heart failure or congestive heart disease) ☐ No ☐ Yes
High blood pressure ☐ No ☐ Yes
High cholesterol (elevated LDL) ☐ No ☐ Yes
Low HDL cholesterol ☐ No ☐ Yes

Do you know your cholesterol level? If so what is it? _____________________
Stroke □ No □ Yes  
Pulmonary embolism (blood clot in lung) □ No □ Yes  
Diabetes □ No □ Yes  
   If yes, how do you control your diabetes?  
      insulin injection □ No □ Yes  
      oral anti-diabetes medications □ No □ Yes  
      diet □ No □ Yes  

Have you ever had any of the following:  
Coronary artery bypass surgery (CABG) □ No □ Yes  
Coronary angioplasty or balloon angioplasty □ No □ Yes  
Surgery for peripheral vascular disease □ No □ Yes  
Any other heart or lung surgery □ No □ Yes  
   If yes, please specify: ____________________________  

Are you currently taking any medications for the following:  
Heart □ No □ Yes  
Lungs □ No □ Yes  
Blood pressure □ No □ Yes  
Diabetes □ No □ Yes  
Other (If yes, please specify): ____________________________ □ No □ Yes  

Do you NOW smoke tobacco (one or more cigarettes, cigars, pipes per week)? □ No □ Yes  
   If YES, about how many packs of cigarettes (or cigars or pipes) do you smoke a day? _______  
   How many years have you smoked? __________  
   If NO, have you smoked in the past? □ No □ Yes  
      If YES, about how many packs per day? _______  
      How many years did you smoke? __________  
      When did you stop? __________  

Have you had heavy exposure to second hand smoke (others smoking near you)? □ No □ Yes.  
   If yes, please describe exposure: ____________________________  

Do you know your blood pressure? □ No □ Yes  
   If yes, what is it? ____________________________  

Do you have an irregular heart beat? □ No □ Yes  

Family History  
Has anyone in your immediate family (parents, children, grandparents, siblings) ever had any of the following conditions?  
Heart attack (myocardial infarction, coronary occlusion, coronary thrombosis) □ No □ Yes  
   If yes, what sex: M__F__ and at what age__?  
Angina □ No □ Yes  
Heart failure (congestive heart failure or congestive heart disease) □ No □ Yes
Section 3:
Please complete Section 3 below ONLY if you would like to have the screening CT examination of the LUNGS. Otherwise, skip to Section 4.

Patient History

Has a doctor ever told you that you have the following conditions:

Lung cancer  □ No  □ Yes
   If yes, please describe treatment:________________________________________

Other type of cancer  □ No  □ Yes
   If yes, what type?

Asthma  □ No  □ Yes

Emphysema  □ No  □ Yes

COPD  □ No  □ Yes

Have you ever had any of the following:

Any heart or lung surgery  □ No  □ Yes
   If yes, please specify: __________________________________________

Are you currently taking any medications for the following:

Lungs  □ No  □ Yes
   Other (If yes, please specify): ______________________________________

Other (If yes, please specify): □ No  □ Yes

Do you NOW smoke tobacco (one or more cigarettes, cigars, pipes per week)?  □ No  □ Yes
   If YES, about how many packs of cigarettes (or cigars or pipes) do you smoke a day? _______
      How many years have you smoked? ________
   If NO, have you smoked in the past?  □ No  □ Yes
      If YES, about how many packs per day? ________
      How many years did you smoke? ________
      When did you stop? ________

Have you had heavy exposure to second hand smoke (others smoking near you)?  □ No  □ Yes.
   If yes, please describe exposure:________________________________________

At your work, are you exposed to chemicals or other materials that can cause lung cancer?  □ No  □ Yes
   If yes, please describe exposure:________________________________________

Do you have shortness of breath?  □ No  □ Yes
Family History

Has anyone in your immediate family (parents, children, grandparents, siblings) ever had any of the following conditions?

a. Lung cancer
   ☐ No  ☐ Yes
b. Other type of cancer
   If yes, what type?
   ☐ No  ☐ Yes
c. Asthma
   ☐ No  ☐ Yes
d. Emphysema
   ☐ No  ☐ Yes
e. COPD
   ☐ No  ☐ Yes
f. Other major disease
   If yes, please specify
   ☐ No  ☐ Yes

Section 4:
Please complete the Section 4 below ONLY if you would like to have the screening CT examination of the COLON.

Patient History

Has a doctor ever told you that you have the following conditions:

Cancer
   If yes, what type?
   ☐ No  ☐ Yes
Colon polyp (adenomatous type)
Familial adenomatous polyposis
Inflammatory bowel disease (such as Ulcerative colitis or Crohn’s disease)
Other major disease
   If yes, please specify
   ☐ No  ☐ Yes

Are you currently taking any medications:
   If yes, please specify:
   ☐ No  ☐ Yes

Family History

Has anyone in your immediate family (parents, children, grandparents, siblings) ever had any of the following conditions?

Cancer
   If yes, what type?
   ☐ No  ☐ Yes
Colon polyp (adenomatous type)
Familial adenomatous polyposis
Other major disease
   If yes, please specify
   ☐ No  ☐ Yes