

## National Lung Screening Trial (NLST)

### ANNUAL STUDY UPDATE (ASU)

#### For Office Use Only

Screening Center ID:  __ __  Screening Center Staff ID:  __ __ __ __  Study Year: T __	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;">                     Initials Complete: _____                      Initials QC: _____                 </td> <td style="width: 40%; padding: 5px; text-align: center; border: 1px solid black;">                     Participant ID Label                 </td> </tr> </table>	Initials Complete: _____ Initials QC: _____	Participant ID Label
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**We need to find out about all health care visits you have had in the period from (\_\_\_\_/\_\_\_\_/\_\_\_\_) to the present. Please answer the following questions as best you can. *If you cannot remember an exact date, please provide an approximate date.***

- 1. In the period from (\_\_\_\_/\_\_\_\_/\_\_\_\_) to the present, have you been diagnosed with cancer by a health care provider?** (Do not include basal-cell or squamous-cell skin cancers.)
- Yes  
 No (If no, go to Item 4)
- 2. What type of cancer was diagnosed?** (Please record all cancers diagnosed during this period except basal-cell and squamous-cell skin cancers.)

Type/Site of Cancer (breast, lung, etc)	Date of Diagnosis	Hospital or Clinic Where the Cancer was Diagnosed
A. _____	____/____/____	_____
B. _____	____/____/____	_____
C. _____	____/____/____	_____

**3. What is the name, phone number and address of the health care provider who diagnosed the most recent cancer?**

FULL NAME OF PROVIDER OR CLINIC

STREET ADDRESS 1	STREET ADDRESS 2	SUITE OR OFFICE NO
CITY	STATE	ZIP
TELEPHONE 1 ( )	TELEPHONE 2 ( )	FAX NUMBER: ( )

4. Have you smoked any cigarettes, even a puff, in the last seven days?

- Yes
- No

5. In the past 12 weeks, have you had pneumonia or an acute respiratory infection that was treated with antibiotics by a physician?

- Yes
- No

6. Who completed this questionnaire? (Please mark one)

- Study Participant
- Spouse
- If someone else provided this information, please specify their name and relationship:

Name and Relationship: \_\_\_\_\_

7. What is today's date? |\_\_| |\_\_| |\_\_| |\_\_| | 2 | 0 |\_\_| |\_\_|  
MO DAY YEAR

8. Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you for completing this questionnaire. Please return this form in the enclosed envelope.**

*(SC Name)*  
*(Address)*