

Screening Form

To be completed by participant (please print)

First Name _____ Last Name _____ Age ____ DOB ____/____/____ Sex M F
 Address _____ City _____ State _____ Zip _____
 Phone (____) _____ Occupation _____ E-mail Address _____

Please circle or fill in responses to the following statements:

I have been treated for skin cancer of the head and neck. Yes No Other cancer: Yes No Location _____
 I have family members who have been treated for cancer of the head and neck. Yes No Location _____
 I have had prior medical, surgical, or radiation treatments to the head and neck region. Yes No Location _____
 I currently use tobacco. Chewing Snuff Cigarettes Cigars Pipes None
 I formerly used tobacco. Chewing Snuff Cigarettes Cigars Pipes None
 In my lifetime, I used tobacco for _____ years with an average of _____ per day.
 In my lifetime, I drank alcoholic beverages for _____ years with an average of _____ drinks per day.

Please check any of the following head and neck problems you currently have:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Change in voice | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Earache | <input type="checkbox"/> Swelling in head or neck |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Swallowing difficulty | <input type="checkbox"/> Denture problems |
| <input type="checkbox"/> Sore in mouth | <input type="checkbox"/> Tooth or gum problem | <input type="checkbox"/> Growth in neck | <input type="checkbox"/> Red or white patches in mouth |

Did you know that any of these problems could be the earliest sign of a head or neck cancer? Yes No
 Has anyone ever shown you how to do an oral self-examination? Yes No
 Would you be interested in volunteering to promote awareness of this disease? Yes No
 Has this program increased your knowledge and awareness of this disease? Yes No

RELEASE OF LIABILITY

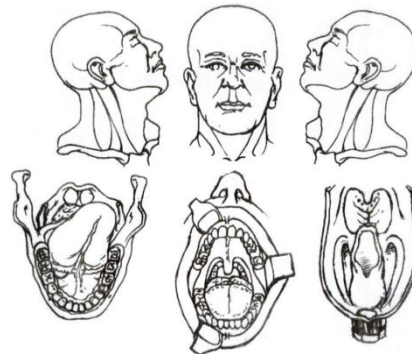
I hereby release the Head and Neck Cancer Alliance, screening facility, and all health-care personnel from any and all responsibility associated with the evaluation and results. I accept all responsibility for the evaluation, future scheduling and costs of further medical evaluation, diagnostic tests, and treatment in addition to the pursuit of any recommendations provided. I understand that this examination is not intended to be a complete head and neck examination or substitute for any examination performed by future or past practitioners. I am responsible for any follow-up examination, evaluation, or tests and release all other parties from any responsibility. The Head and Neck Cancer Alliance may use the results of this examination and the information on this form for statistical and educational purposes, but my name will not be released to any other person or organization without my express written consent.

Signature _____ Date _____

SCREENING EXAMINATION – To be completed by practitioner

Please check all that apply:

Site	Normal	Abnormal	Not evaluated
Skin			
Ears			
Nose			
Oral Cavity			
Oropharynx			
Larynx			
Salivary glands			
Thyroid glands			
Neck			



_____ Routine follow-up with primary care physician _____ Further head and neck evaluation _____ Immediate consultation for suspected neoplasm

Other _____

Signature _____ Date _____