Colorectal Cancer Screening Questionnaire

Name ___________________  Birth Date _______  Today’s Date _________

Are you 50 years of age or older?
□ Yes  □ No

Has a parent, brother, sister, or child of yours ever had colorectal cancer or precancerous polyps?
□ Yes  □ No  □ Do not know

Have you ever had polyps, inflammatory bowel disease, ovarian or endometrial cancer, or radiation to your lower abdomen or pelvis?
□ Yes  □ No  □ Do not know

Have you ever been screened for colon or rectal cancer before?
□ Yes  □ No  □ Do not know

If yes, check the box if you have ever had one of these screenings:

☐ Colonoscopy: A doctor looked at your entire colon and rectum with a special instrument while you were asleep (with anesthesia). You had a liquid diet and took medication to clean out your bowels before the test.

☐ Fecal Occult Blood Test: You used a flat stick to put samples of a bowel movement on a special card and returned it to your doctor or a laboratory for testing.

☐ Flexible Sigmoidoscopy: A doctor looked at the lower part of your colon and rectum with a special instrument. You had a liquid diet and took medication to clean out your bowels before the test.

What questions do you have about colorectal cancer screening?
___________________________________________________________________________
___________________________________________________________________________

Colorectal cancer can affect any of us. Screening can prevent colorectal cancer by removing precancerous polyps early! Early detection saves lives. Talk to your provider today about screening!

To be completed with your healthcare provider:

Today, _________________, your provider recommended that you have:

(Date)

☐ Colorectal cancer screening with a ____________________________

(Recommended screening method)

☐ Breast cancer screening with a  ☐ Clinical Breast Exam  ☐ Mammogram

☐ Cervical cancer screening with a  ☐ Pap test  ☐ Pap with HPV co-test

Your next steps are:

___________________________________________________________________________

Over
Breast & Cervical Cancer Screening Questionnaire

Name ______________________  Birth Date ________  Today's Date ________

Are you 40 years of age or older? □ Yes □ No
Has your mother, sister, or daughter ever had breast cancer? □ Yes □ No □ Do not know
Have you ever had breast cancer? □ Yes □ No □ Do not know
Have you ever had a mammogram?
   □ Yes □ No □ Do not know
   If yes, when was the mammogram done? ____________________________
   Where was the mammogram done? ____________________________
   What were the results? □ Normal □ Abnormal □ Do not know
Have you ever had cervical cancer? □ Yes □ No □ Do not know
Have you ever had a Pap test?
   □ Yes □ No □ Do not know
   If yes, when was the Pap test done? ____________________________
   Who did the Pap test? ____________________________
   What were the results? □ Normal □ Abnormal □ Do not know
What questions do you have about breast and cervical cancer screenings?
________________________________________________________________________
________________________________________________________________________

As women get older, they are at greater risk of breast and cervical cancer. Regular screening can help find cancer early when it is the most easily treated. Talk to your provider today about screening!

If you need help paying for screening or want more information, please call to learn about programs that could help you get screened!

1-800-477-9774
Maryland Cancer Hotline (toll free)