CANCER SCREENING FORM

SERIAL NUMBER_____

CANCER SCREENING AND EARLY DIAGNOSIS FORM

FACILITY NAME_____ DATE_____

SECTION A: SOCIO-DEMOGRAPHIC DATA

Inpatient/Outpatient number_____ National ID no _____

Name_____ Sex_____ Age (years) _____

Marital status_____ No. of children _____

Patient phone no_____Address_____

Next of kin (nok) name_____ relationship to n.o.k_____ N.O.K. phone No_____

Current residence: county_____Sub-county_____Ward/Estate_____

Length of time lived in current residence (years) _____

Highest educational level_____ Occupation_____

Ethnicity/Race_____

Where did you learn about this screening program?

Word of mouth ☐ From media ☐

Healthcare worker ☐ other ☐ (specify) _____

Screening service point: MCH/FP ☐ CCC ☐ GOPC ☐ OUTREACH ☐

other ☐ (specify) _____

Referred to this facility? Yes ☐ No ☐ if yes, from_____

REASON FOR REFERRAL_____

VITAL SIGNS: BP_____ PULSE RATE_____

WEIGHT_____ HEIGHT_____BMI_____

BLOOD SUGAR LEVEL_____

SECTION B: FAMILY HISTORY

Any history of cancer in the family?

If yes, which cancer? _____

Who was affected? Parent ☐ Sibling ☐ 1st or 2nd degree relative ☐

Other ☐ (Specify) _____

What was the age at diagnosis? (Years)_____

What was the sex of the person affected? Male ☐ Female ☐

SECTION C: CLINICAL/RISK FACTOR HISTORY

Tick as appropriate

RISK FACTORS

Risk factors history	**Tick**
Smoking	
Alcohol intake	
Previous chemotherapy or radiation treatment	
Any other (specify)	

COMMON SYMPTOMS

Symptom history	**Tick**
Recurrent indigestion (dyspepsia)	
Blood in stool	
Yellow eyes	
Blood in urine	
Epistaxis (nose bleeding)	
Difficulty in swallowing	
General weight loss	
Easy fatigability, palpitations	
Abnormal vaginal bleeding	
Enlarging/changing skin moles	
Chronic skin ulcers	
Any lumps or swellings	
Chronic cough	
Persistent headaches	
Changing bowel habits	
Others (specify)	

SECTION D: TYPE OF CANCER SCREENING

Cancer	Visit type	Screening modality	Last screening modality done	Date of last screening
Cervical	Initial screening ☐ Repeat screening ☐ Post-treatment screening ☐	HPV testing ☐ Pap smear ☐ VIA/VILI ☐		
Breast	Initial screening ☐ Repeat screening ☐ Post-treatment screening ☐	Clinical breast examination ☐ Ultrasound ☐ Mammogram ☐		
Prostate	Initial screening ☐ Repeat screening ☐ Post-treatment screening ☐	DRE in combination with PSA testing ☐		
Colorectal	Initial screening ☐ Repeat screening ☐ Post-treatment screening ☐	Fecal occult blood test ☐ Colonoscopy ☐		
Retinoblastoma (known Retinoblastoma 1 mutation or positive family history)	At birth ☐ Vaccination clinic ☐	Eye exam under anaesthesia ☐		

Retinoblastoma screening frequency

1. Known RB 1 mutation on genetic testing:
    - Every 6 weeks until 1 year, then every 3 months until 3 years, then every 6 months until 6 years
2. No genetic testing available
    - Option 1 – positive family history for parent
        - At birth, then every month for 3 months, then every 3 months for 3 years
    - Option 2 – positive family history for sibling
        - At birth, then every month for 3 months, then every 3 months for 1 year

SECTION E: SCREENING RESULTS

Cancer	Screening modality	Results/findings	Recommended action
Cervical	▪ HPV ▪ Pap smear ▪ VIA/VILI		
Breast	▪ Clinical breast examination ▪ Ultrasound (<40 years) ▪ Mammogram ≥ 40 years		
Prostate	▪ DRE in combination with PSA testing		
Colorectal	▪ Fecal occult blood test ▪ Colonoscopy		
Retinoblastoma	▪ Eye exam		

SECTION F: FOLLOW UP

Return date_____

Referred to_____

Referred for further screening (give reasons)

_____

_____

Health service provider:

Name_____**Cadre**_____**Signature**_____