

National Cancer Screening Program

Last Name		Resident Reg. No.		Telephone	Home	
Given Name					Mobile phone	
<input type="checkbox"/> Health insurance <input type="checkbox"/> Medicaid recipient			E-mail			
			How to Receive the Health Examination Result Report		<input type="checkbox"/> Mail <input type="checkbox"/> Email	
Current address						Postal code
						-

※ These are questions about cancer.

※ Please answer the following questions about your **present condition** by ticking the appropriate box.

1. Do you have **any uncomfortable** areas in your body? Where?

① Yes (symptom: _____) ② No

2. In the **last 6 months**, have you **experienced a weight decrease over 5 kg** without any specific reason?

① No ② Yes; total weight loss (_____ kg)

3. Do you have any family members, including yourself, who have cancer?

Type of cancer	No	No Idea	Yes (You may select multiple diseases)				
			You	Parents	Brother	Sister	Kids
Gastric Cancer							
Breast Cancer							
Colon and Rectal Cancer							
Hepatoma							
Cervical Cancer							
Lung Cancer							
Others (_____)							

4. Have you ever undergone **these examinations** before?

Examination		Period			
		Over 10 years ago or none	Within 1 year	Between 1 and 2 years	Between 2 and 10 years
Gastric Cancer	Photography				
	Endoscopy				
Breast Cancer	Mammogram				
Colon and Rectal Cancer	Fecal Occult Blood (Stool Test)				
	Barium Enema				
	Endoscopy				
Cervical Cancer	Cervical Skin Exam				
Lung Cancer	Chest CT				
Hepatoma	Liver Ultrasound	None	Within 6 months	Between 6 and 12 months	Over more than 1 year

※ These are questions only about gastric cancer, hepatoma, and colon and rectal cancer.

※ Please mark 'O' that **corresponds to your condition**.

5. Have you ever been diagnosed with any **stomach disease**?

Disease	Gastric ulcer	Gastritis	Duodenal ulcer	Polyps	Others (write)	None
Yes						

6. Have you ever been diagnosed with any **colon disease**?

Disease	Colon polyps	Ulcerative colitis	Crohn's disease	Hemorrhoids	Others (write)	None
Yes						

7. Have you ever been diagnosed with any **liver disease**?

Disease	Hepatitis B carrier	Hepatitis B	Hepatitis C	Cirrhosis	Others (write)	None
Yes						

8. Have you ever been diagnosed with any **lung disease**?

Disease	Chronic obstructive pulmonary disease (COPD) (chronic bronchitis, emphysema, etc.)	Pulmonary tuberculosis (TB)	Pulmonary nodules	Interstitial lung disease (ILD)	Pneumoconiosis	Others (write)	None
Yes							

※ These are questions only about breast cancer and cervical cancer. (For women only.)

9. When was your first menstrual period?

- ① Age: _____ ② I have not gotten my period yet.

10. Do you still experience menstrual periods?

- ① Yes ② I have removed my cervix or uterus.
③ Menopause (age: _____)

11. Have you ever taken any medication or hormonal treatment to relieve any menopausal symptoms?

- ① Never ② Yes; for less than 2 years
③ Yes; for a period between 2 and 5 years ④ Yes; for more than 5 years ⑤ No idea

12. How many children do you have?

- ① 1 ② More than 2 ③ No child

13. How long did you breast-feed your child?

- ① Less than 6 months ② Between 6 and 12 months ③ More than 1 year ④ Not applicable

14. Have you been diagnosed with a **benign** tumor?

(Benign tumor is only a tumor; it is **not cancer**, and it is **not even cancerous**.)

- ① Yes ② No ③ No idea

15. Have you taken any birth control pills?

- ① Never ② Less than 1 year
③ Over 1 year ④ No idea