

# National Cancer Screening program

Regular checkup

Life cycle-based checkup

First name		Residential ID No.		Tel. No.	Home	
Given name			Cell phone			
<input type="checkbox"/> health insurance <input type="checkbox"/> medicaid recipient			E-mail address			
current address					post code	
						-

※ Do you agree to receive health information or notices from the NHIC (National Health Insurance Cooperation), KCDC (Korea Centers for Disease Control and Prevention), NCC(National Center for Cancer), and/or health centers by letters or e-mail? (please check  ) Yes  No

※ These are questions about Cancer.

※ Please complete 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. Did you lose more than 5kg in the last 6 months without any reasons?

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 0				
			You	Parents	Brother	Sister	Kids
Gastric Cancer							
Breast Cancer							
Colon and Rectal cancer							
Hepatoma							
Cervical cancer							
Other ( _____ )							

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				
	Barium Enema				
	Endoscopy				
Cervical Cancer	Cervical Skin Exam				
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, Colon and Rectal Cancer.**

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

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

Disease	Gastric ulcer	Gastritis	Duodenal ulcer	Polyp	Other (write)
Yes					

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

Disease	Polyp-rectal	Ulcerative colitis	Crohn's disease	Hemorrhoid	Other (write)
Yes					

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

Disease	Hepatitis B carrier	Hepatitis B	Hepatitis C	Cirrhosis	Other (write)
Yes					

**※ These are questions Only about Breast Cancer, Cervical Cancer (Only for Women)**

8. When was your first menstrual period ?

- ① age \_\_\_\_\_      ② Not yet

9. Do you still have menstrual period ?

- ① Yes                  ② remove cervix or uterus  
③ menopause (age : \_\_\_\_\_ )

10. Have you ever taken any medications or hormonal treatment to relieve any menopausal symptoms?

- ① No never          ② taking less 2 years  
③ between 2 and 5 years      ④ more than 5 years      ⑤ no idea

11. How many children do you have?

- ① 1      ② more than 2      ③ no child

12. How long did you breast-feeding your child?

- ① less than 6 months    ② between 6 and 12 months    ③ more than 1 year    ④ none

13. Have you ever been diagnosed with a benign tumor?

(benign tumor is Not a cancer, just a tumor)

- ① Yes      ② No      ③ No idea

14. Have you ever taken any birth control pills?

- ① No never      ② less than 1 year  
③ over 1 year      ④ No idea