

THIS BOX FOR OFFICE USE ONLY

Date: ___/___/___	Enrollment Site _____	Informed Consent Signed <input type="checkbox"/>
Eligible N <input type="checkbox"/>	Y <input type="checkbox"/>	
Average Risk <input type="checkbox"/>		Above Average Risk <input type="checkbox"/>
FOBT provided <input type="checkbox"/>		Colonoscopy referral made <input type="checkbox"/>
		Date colonoscopy scheduled _____

MICHIGAN COLORECTAL CANCER SCREENING PROGRAM  
RISK ASSESSMENT

THIS FORM WILL BE USED TO DETERMINE IF YOU ARE ELIGIBLE FOR A COLORECTAL CANCER SCREENING PROGRAM, AND THE TYPE OF SCREENING TEST YOU SHOULD RECEIVE.

I AGREE THAT THE MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, MICHIGAN PUBLIC HEALTH INSTITUTE, AND THE AGENCY NAMED ABOVE MAY USE MY ANSWERS TO THE QUESTIONS ON THIS FORM FOR STATISTICAL PURPOSES ONLY. BEFORE I GET SCREENED FOR COLORECTAL CANCER, I WILL BE GIVEN DETAILED INFORMATION ABOUT THE TESTING AND SIGN AN INFORMED CONSENT FORM.

NO  YES

Symptoms

1. Have you had lower abdominal (belly) pain or unexplained weight loss in the last six months that is unexplained, ongoing (persistent) or worsening? NO  YES

If yes, please see your physician.

2. Have you had any of these problems in the last six months that are unexplained, ongoing (persistent) or worsening? NO  YES

If yes, check any that apply:

- Bright red blood from rectum
- Bloody or black stool
- Narrowing of stools (pencil-size)

Colorectal Cancer Screening History

3. Have you ever completed a home stool test? NO  YES   
Was it in the last year? NO  YES  Results: Positive  Negative

4. Have you ever had a colonoscopy? NO  YES   
If yes, when was your last? \_\_\_\_\_ Results: Positive  Negative   
Why was the procedure done? \_\_\_\_\_

Risk Assessment

5. Have you ever been told you had colon or bowel cancer? NO  YES   
a. Date of first diagnosis of colon or bowel cancer: \_\_\_\_\_  
b. Date of surgery and/or treatment: \_\_\_\_\_

CLIENT NAME \_\_\_\_\_ CLIENT/MBCIS# \_\_\_\_\_  
 DOB \_\_\_\_\_ AGENCY \_\_\_\_\_  
 INITIALS \_\_\_\_\_ DATE \_\_\_\_\_

6. Have you ever been told you had a polyp in the colon? NO  YES   
 a. Were you told it was pre-cancerous? NO  YES   
 b. How many pre-cancerous polyps?  One Small  One Large  More than two  
 c. Date of first diagnosis of pre-cancerous polyps: \_\_\_\_\_  
 d. Age of first diagnosis of pre-cancerous polyps: \_\_\_\_\_
7. Have you ever been treated for ulcerative colitis or Crohn's Disease? NO  YES   
 a. If ulcerative colitis, date of diagnosis: \_\_\_\_\_

**Family Risk**

8. Has your parent, sister, brother, or child had colon or bowel cancer or pre-cancerous colon polyps? NO  YES

If you answered yes, please specify:

Parent, sister, brother, or child (specify)	Colorectal Cancer or Cancerous Colon Polyps (specify)	Age of onset

9. Has your parent, sister, brother, or child been told they have an inherited (genetic) form of colon or bowel cancer? NO  YES
10. Have you or your parents, sister, brother, or child had any of these cancers: Uterus (Uterine, Womb, or Endometrial), Ovary (Ovarian), Kidney, Stomach, Gall Bladder, Ureter or Renal Pelvis, Small Bowel? NO  YES

If you answered yes, please specify:

Self or parent, sister, brother, or child (specify)	Cancer (specify)	Age of onset

11. Have you or a family member ever had counseling about genetic testing? NO  YES   
 If yes, please check who received counseling about genetic testing: You  Family Member   
 Why was the counseling about genetic testing conducted? \_\_\_\_\_

**Other Health Behaviors**

12. Has a doctor, nurse, or other health care provider ever told you that you have diabetes? NO  YES
13. Do you currently smoke cigarettes?  
 Every day (how many do you smoke each day? \_\_\_\_\_ )  
 Some days (how many do you smoke each week? \_\_\_\_\_ )  
 Not at all  
 I used to smoke, but quit \_\_\_\_\_ months/years ago (circle one).

CLIENT NAME \_\_\_\_\_ CLIENT/MBCIS# \_\_\_\_\_  
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