July 2018

Vhi Medical Centre

CancerCheck
Questionnaire

Please complete pages 2 to 6 before your appointment.

You will be asked to complete page 1 in Vhi Medical Centre during your appointment.

Affix identification label here

Section 1. **Consent form**

The services provided in Vhi Medical Centres assess specific important aspects of your health. They are designed to help identify factors which may cause potential health issues for you in the future, with the aim of giving you and your GP the information necessary to address these and reduce your risk of future problems.

The tests we provide have been selected to cause as little discomfort or inconvenience as possible. Taking blood tests does involve some discomfort and may cause minor bruising. Occasionally this bruising may be more severe.

Please read the enclosed Information Pack carefully as it contains:

- A description of the tests included
- Medical inclusion/exclusion criteria as some of the tests are not available to everyone and are subject to medical suitability
- Instructions to help you prepare for your appointment

Informed Consent

Please do not sign in advance.

- I have read and understand the information provided about the service in the Information Pack.
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that the service is not designed to evaluate established illness and results relating to prior illness may be misleading.
- I understand that the tests performed are not suitable for assessing active medical problems.
- I accept that a copy of my report will be sent to my GP and if any serious issues are identified my GP may be contacted directly.
- I also accept that if there are any abnormal results I will be advised to attend my GP and/or Consultant for further management, and I will be responsible for acting on that advice.
- I accept that Vhi may also share my data with trusted third parties who process data on its behalf (e.g. laboratory, scanning services) inside and outside of the European Economic Area. Data may also be shared with state bodies as required by law.
- I understand that any follow-up treatment with my GP and/or Consultant is not part of the service, but I may be able to submit the receipt as part of an out-patient claim subject to the terms and conditions of my chosen insurance plan.

Data Protection Notice

In order to provide the Screening service to you, Vhi Health Services will process the personal data that you have provided, together with any personal data that you have authorised third parties to provide to us. Processing of your personal data is required in order for us to provide the Screening service and for us to be able to operate the business of providing health services.

Vhi Health Services DAC of Waverly Office Park, Old Naas Road, Dublin 12 is the company that controls and is responsible for processing the personal data in Vhi Medical Centres' services. It will process your personal data in accordance with the Vhi Data Protection Statement which has previously been provided to you. If you would like another copy of the Vhi Data Protection Statement it is available at Vhi.ie, or you can request a copy by calling us on (056) 444 4444 or 1890 44 44 44.

Declaration

By signing this consent form, you explicitly consent to Vhi processing your details for the purposes described above.

I understand that in certain circumstances, I may be advised to visit my GP for further assessment and information will be disclosed to him/her. I understand that any additional follow up health treatment arising from the screening service is not included and is subject to the normal rules of my health insurance policy.

I hereby consent to the above tests being conducted, the use of personal information relating to me for the purpose described above and the disclosure of such information to the parties referred to above for that purpose.

Participant's signature: _____ Date: D D M M Y Y

Witness's signature: _____ Date: D D M M Y Y

Section 2. **Personal information**

Surname:

Forename:

Address:

Occupation:

Preferred contact phone number:

Gender: Male ☐ Female ☐

Date of birth: ☐☐ ☐☐ ☐☐

Race/ethnicity: African ☐ Asian ☐

Caucasian (white) ☐ Other ☐

General practitioner name:

General practitioner address:

Next of Kin name:

Next of Kin contact number:

Section 3. **Medical history**

Please indicate if you have been diagnosed with any of the following conditions:

a. COPD/emphysema: Yes ☐ No ☐

b. Cancer: Yes ☐ No ☐

c. Crohn's/ulcerative colitis: Yes ☐ No ☐

Other medical conditions or issues not listed (please specify):

If you answered Yes to any of the above questions, please explain briefly:

Please list **all** medications (including prescribed/over the counter/herbal supplements):

Do you have allergies to: Latex ☐ Plasters ☐ Other (including medications) ☐

Details:

Pain: Are you in pain anywhere right now? Yes ☐ No ☐ If so, where?

Can pain ever keep you from sleeping at night, or keep you from participating in activities you enjoy? Yes ☐ No ☐

Are you in pain every day? Yes ☐ No ☐

What would you rate your pain on a scale of 1-10? ☐ *1 = Very mild* *10 = Extreme pain*

Details:

Affix identification label here

Section 4. **Family history**

Please give details of any cancer related conditions in your family.

	Diagnosis	Age of diagnosis	If deceased, what was their age at death?
Mother			
Father			
Brother			
Sister			
Child			
Other relative			

Section 5. **Social history**

Smoking

Please tick the box that is applicable to you:

a. Smoker ☐ **b.** Ex-smoker ☐ **c.** Non-smoker ☐

d. Year started smoking: ☐☐☐☐ **e.** Year stopped smoking: ☐☐☐☐

f. Number of cigarettes: ☐☐ or cigars: ☐☐ or pipe smoked per day: ☐☐

g. E-cigarettes: Which of the following statements best applies to you?

I have never heard of e-cigarettes and I have never tried them ☐

I have heard of e-cigarettes but I have never tried them ☐

I have tried e-cigarettes but I do not use them anymore ☐

I have tried e-cigarettes and still use them on a daily basis ☐

I have tried e-cigarettes and still use them less than daily ☐

Don't know ☐

Alcohol intake and drug use

Do you drink alcohol: Yes ☐ No ☐ Occasionally/seldom ☐

If you answered Yes to the above question please indicate how many of each of the following you would consume in an average week:

a. Pints of beer/cider: ☐☐ **b.** Bottles of beer: ☐☐ **c.** Glasses of wine: ☐☐

d. Measure of spirits (1 short): ☐☐ **e.** Alco-pops: ☐☐ **f.** Cans of beer/cider: ☐☐

How many days of the week do you have six or more standard drinks?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

Note one standard drink is a pub measure of spirits (35.5ml), a small glass of wine (12.5%vol) or half a pint of normal strength beer

Drug use (including illegals drug use and the use of prescription drugs other than as prescribed:

Have you ever felt that you ought to cut down on your drinking or drug use? Yes ☐ No ☐

Have people annoyed you by criticising your drinking or drug use? Yes ☐ No ☐

Have you ever felt bad or guilty about your drinking or drug use? Yes ☐ No ☐

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? Yes ☐ No ☐

Physical activity/exercise

Tick the appropriate box

How often do you exercise for 30 minutes or more*

a. Seldom/never ☐

b. Less than once a week ☐

c. 1-2 days a week ☐

d. 3-4 days a week ☐

e. 5-6 days a week ☐

f. Daily ☐

* Note: this would be exercise that moderately increases your breathing and heart rate, and makes you sweat (such as brisk walking, cycling, swimming, jogging, aerobics or climbing stairs).

Affix identification label here

Stress

On scale of 1-10 how stressed are you?

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

1 = Not stressed 10 = Extremely stressed

Over the last 2 weeks how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐

Dietary information

How many portions/servings of each of the following foods to do you eat on average per day?

Food type ** Note a portion is usually a small fist sized amount*	Less than every day	Very small amounts	1 portion	2 portions	3 portions	4 portions	5 portions or greater
Vegetables, salad or fruit	☐	☐	☐	☐	☐	☐	☐
Wholemeal cereals, breads, potatoes, pasta or rice	☐	☐	☐	☐	☐	☐	☐
Milk, yoghurt or cheese	☐	☐	☐	☐	☐	☐	☐
Meat, poultry, fish, eggs, beans or nuts	☐	☐	☐	☐	☐	☐	☐
Fats, spreads or oils	☐	☐	☐	☐	☐	☐	☐
Foods and drinks high in fats, sugar or salt	☐	☐	☐	☐	☐	☐	☐

How many glasses/cups (200ml) of water or other fluids do you drink on average per day? ☐☐

Section 6. **For female participants**

	Yes	No
Do you still menstruate?	☐	☐
Have you ever been pregnant? If Yes, please state number of pregnancies: ☐☐	☐	☐
Do you examine your breasts regularly?	☐	☐
Do you have breast implants?	☐	☐
Have you ever had a mammogram? If Yes, please state date performed and result: Date: ☐☐☐☐☐☐ Result:	☐	☐
Do you participate in cervical screening? If Yes, when was your last smear test: Date: ☐☐☐☐☐☐ Result:	☐	☐
Have you had the HPV vaccine?	☐	☐

Section 7. **For male participants**

	Yes	No
Do you have lumps or swelling in your testicular region? If Yes, please give details: _____ _____	☐	☐
Do you examine your testicles regularly?	☐	☐
Have you ever had a prostate screening test? If Yes, please state date performed and result: Date: ☐☐☐☐☐☐ Result:	☐	☐

Section 8. **OFFICE USE ONLY:**

Affix identification label here

Surname: Forename: Date of birth: ☐☐ ☐☐ ☐☐

Gender: Male ☐ Female ☐ Patient ID:

FOR COMPLETION BY DOCTOR: (1 of 3)

Risk assessment

Does person understand information? Verbally Yes ☐ No ☐ Written Yes ☐ No ☐

Was person in hospital (here or abroad) in last 6 months? Yes ☐ No ☐

Does person have any allergies? Yes ☐ No ☐ *If Yes, refer to Medical history section*

Do any of the following risk factors put person at increased risk of slips, trips and falls?

Walking aids	Yes ☐	No ☐	Vision impaired	Yes ☐	No ☐
Obese	Yes ☐	No ☐	History of unexplained falls	Yes ☐	No ☐
Elderly (unassisted)	Yes ☐	No ☐			

Record if any extra precautions taken:

Questionnaire fully completed Yes ☐ No ☐ *Please sign and date any clarifications/changes*

PSA/DRE

Eligible for PSA/DRE testing? Yes ☐ No ☐

Taking prostate medication? Yes ☐ No ☐

Discussed with person? Yes ☐ No ☐

Do they want test? Yes ☐ No ☐

PSA requested on sample lab request form? Yes ☐ N/A ☐

Is patient on anticoagulant (e.g. warfarin)? Yes ☐ No ☐ *(If Yes, advise of haemetoma risk)*

Previous Abnormal PSA? Yes ☐ No ☐ *If Yes, Date of Test:*

Blood sample bottle labelled Yes ☐ N/A ☐

Section 8. **OFFICE USE ONLY (continued):**

FOR COMPLETION BY DOCTOR: (2 of 3)

Colon cancer screening: (Extra Only)

Is person eligible for colon screening? Yes ☐ No ☐

= Aged 50 - 74
= No history of colon cancer, inflammatory bowel disease, crohn's disease, ulcerative colitis
= No history or family history of polyposis coli or hereditary non polyposis coli

Given sample pack Yes ☐ No ☐

Assessment:

Height ☐☐☐ Weight ☐☐☐ BMI ☐☐☐ Waist circumference ☐☐☐

Assessment of lifestyle risk and advice given:

Assessment of past and family history and advice given:

Assessment of symptoms and discussion:

Examination and self-examination advice/education:

Test results and discussion:

Section 8. **OFFICE USE ONLY (continued):**

Affix identification label here

FOR COMPLETION BY DOCTOR: (3 of 3)

Confirmed understanding of advice and education requirements: Yes ☐ No ☐

Was person given literature/education material? Yes ☐ Not required ☐ Offered but declined ☐

If Yes, please specify:

Date: ☐☐☐☐☐☐ Signature:

MRCN: