# COLON CANCER
SCREENING FORM

## PERSONAL INFORMATION

Full Name :

Age :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number :

Gender : Male Female

## FAMILY AND PERSONAL HISTORY

Any personal history of colon cancer? Yes No

Family history of colon cancer? Yes No

If yes, please specify the relatives affected:

## SYMPTOMS AND RISK FACTORS

Any gastrointestinal symptoms? Yes No

If yes, please specify (e.g., blood in stool, changes in bowel habits):

Dietary Habits:

- High-fiber diet
- Low-fiber diet
- Vegetarian
- Meat lover
- High-fiber diet
- Other (please specify): ______________________________

Previous Colonoscopies or Screenings: Yes No

If yes, please provide the date of the last screening:

THANK YOU FOR YOUR INFORMATION