



HEAD AND NECK CANCER  
**ALLIANCE**



ORAL HEAD & NECK  
CANCER AWARENESS WEEK

**ORAL, HEAD AND NECK CANCER AWARENESS WEEK**  
(FORMERLY THE YUL BRYNNER ORAL, HEAD AND NECK CANCER FOUNDATION)

**To be completed by Participant:** Please Print

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_ Email \_\_\_\_\_

**QUESTIONNAIRE**

I have been treated for skin cancer of the head and neck: Yes No Other Cancer: Yes No Location \_\_\_\_\_  
I have family members who have been treated for cancer of the head and neck: Yes No Location \_\_\_\_\_  
I have had prior medical, surgical or radiation treatments to the head and neck region: Yes No Location \_\_\_\_\_  
I currently use tobacco (please circle): Chewing Snuff Cigarettes Cigar Pipe None  
I have previously used tobacco (please circle): Chewing Snuff Cigarettes Cigar Pipe None  
In my lifetime, I have used tobacco for \_\_\_\_\_ years with an average of \_\_\_\_\_ packs per day.  
I have consumed alcoholic beverages for a total of \_\_\_\_\_ years with an average of \_\_\_\_\_ drinks per day. None

Please check any of the following head and neck problems that you currently have:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Change in voice | <input type="checkbox"/> Bleeding          | <input type="checkbox"/> Earache               | <input type="checkbox"/> Swelling in head/neck      |
| <input type="checkbox"/> Sore Throat     | <input type="checkbox"/> Lump in throat    | <input type="checkbox"/> Swallowing difficulty | <input type="checkbox"/> Denture problems           |
| <input type="checkbox"/> Sore in mouth   | <input type="checkbox"/> Tooth/Gum problem | <input type="checkbox"/> Growth in neck        | <input type="checkbox"/> Red/White Patches in Mouth |

Did you know that any of these could be the earliest sign of a head or neck cancer? Yes No  
Has anyone ever shown you how to perform an oral self-examination? Yes No  
Would you be interested in volunteering to promote awareness of this disease? Yes No  
Has this program increased your knowledge and awareness of this disease? Yes No

**RELEASE OF LIABILITY**

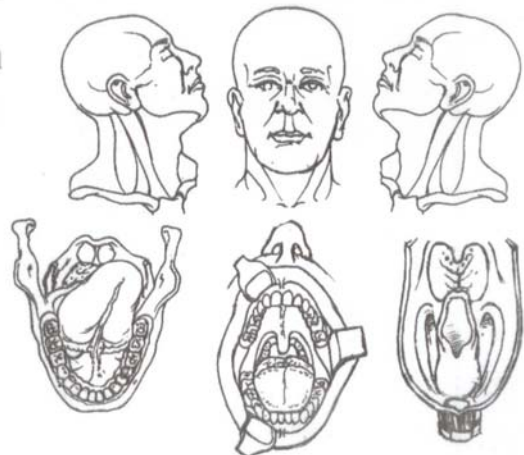
I hereby release the Head and Neck Cancer Alliance, screening facility, and all healthcare personnel from any and all responsibility associated with the evaluation and results. I accept all responsibility for the evaluation, future scheduling and costs of further medical evaluation, diagnostic tests and treatment in addition to the pursuit of any recommendations provided. I understand that this examination is not intended to be a complete head and neck examination or substitute for any examination performed by future or past practitioners. I am responsible for any follow up examination, evaluation, or tests and release all other parties from any responsibility. The Head and Neck Cancer Alliance may use the results of this examination and the information on this form for statistical and educational purposes, but my name will not be released to any other person or organization without my express written consent.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SCREENING EXAMINATION**

**To be completed by Practitioner:** Please check all that apply

SITE	Normal	Abnormal	Not evaluated
Skin	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Oral Cavity	_____	_____	_____
Oropharynx	_____	_____	_____
Larynx	_____	_____	_____
Salivary Glands	_____	_____	_____
Thyroid Glands	_____	_____	_____
Neck	_____	_____	_____



1. \_\_\_\_\_ Routine follow up with primary care physician
2. \_\_\_\_\_ Further head and neck evaluation may be necessary
3. \_\_\_\_\_ Immediate consultation for suspected neoplasm
4. \_\_\_\_\_ Other: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_