

<p>To be completed by Staff:</p> <input type="checkbox"/> BCCCNP <input type="checkbox"/> Wrap Around

Enrollment Site or Clinic Name: _____ Date: _____

Client Contact Information – Please PRINT

Last Name:		First Name:		M.I.:
Maiden Name:				
Social Security Number:			Birth Date:	
Street Address:		Apt:	City:	
PO Box:		State:	Zip Code:	
County:		Addl. Address		
Phone Number: () -		<input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Pager <input type="checkbox"/> Fax <input type="checkbox"/> Cell May we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alternate Phone Number: () -		<input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Pager <input type="checkbox"/> Fax <input type="checkbox"/> Cell May we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email Address (if available):				

Race and Ethnicity

Are you Hispanic or Latino? Yes No Unknown

<p>Race</p> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native	<p>Ethnicity – mark all that apply</p> <input type="checkbox"/> European <input type="checkbox"/> Middle Eastern, North African, Arab <input type="checkbox"/> African, Caribbean Islander <input type="checkbox"/> Spaniard, Mexican, Central, South or Latin American, Puerto Rican, Cuban <input type="checkbox"/> Canadian/Latin American Indian
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Demographics

<p>Level of Education:</p> <input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate <input type="checkbox"/> Some College <input type="checkbox"/> College graduate	<p>Marital Status:</p> <input type="checkbox"/> Married <input type="checkbox"/> Never married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<p>Employment Status:</p> <input type="checkbox"/> Full Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Part Time <input type="checkbox"/> Retired
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Household Members & Income MUST be complete to ensure payment

<p># of people in the household: (including yourself)</p> <p>Household Yearly Income: \$</p> <input type="checkbox"/> Referred to HMP/Medicaid by BCCCP clinic/agency staff	<p>Insurance Information Provider: Please fax copy of card to BCCCP & retain in medical record</p> <input type="checkbox"/> None <input type="checkbox"/> County Health Plan <input type="checkbox"/> Medicaid # _____ <input type="checkbox"/> Medicare # _____ <input type="checkbox"/> Part A Only <input type="checkbox"/> Blue Cross _____ Contract # _____ Group # _____ <input type="checkbox"/> Other _____ Group Name _____ Contract # _____ Group # _____ Insurance Deductible Amount: \$ _____		<p>My Plan Covers:</p> <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostics <input type="checkbox"/> Treatment
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Provider (Primary Care) Information

Do you have a regular Primary Care Provider (doctor/nurse practitioner/clinic)? Yes No

Do you want your test results sent to this provider? Yes - fill out information below No

Physician Name: _____ Physician Address: _____

Alternate Contact Information

Name: _____ Is this person a: Spouse Child Friend Neighbor Relative Other

Phone Number: () - _____ Email Address (if available): _____

Patient Name: _____

MEDICAL HISTORY	
Recent breast symptoms	
<input type="checkbox"/> Lump <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Skin Changes (dimpling, nipple retraction, scaly skin, etc.) <input type="checkbox"/> Pain <input type="checkbox"/> Other (specify): _____	
Smoking History	
Do you now smoke cigarettes? <input type="checkbox"/> Every Day <input type="checkbox"/> Some Days <input type="checkbox"/> Not At All	
Are you interested in quitting smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not smoke	
Personal Cancer History	
<input type="checkbox"/> BREAST Cancer	Year Diagnosed: _____
<input type="checkbox"/> CERVICAL Cancer	Year Diagnosed: _____
<input type="checkbox"/> COLORECTAL Cancer	Year Diagnosed: _____
<input type="checkbox"/> OVARIAN Cancer	Year Diagnosed: _____
<input type="checkbox"/> OTHER Cancer	Year Diagnosed: _____
Breast and Cervical Screening History	
Ever had a Pap? <input type="checkbox"/> Yes – If “Yes” – Exam Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Ever had an abnormal Pap? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Ever had a Hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Reason for Hysterectomy: _____
Do you have a cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of hysterectomy: _____
Ever had a Mammogram? <input type="checkbox"/> Yes – If “Yes” – Exam Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Ever had a breast biopsy? <input type="checkbox"/> Yes Biopsy Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
Ever had a Clinical Breast Exam (CBE)? <input type="checkbox"/> Yes – If “Yes” – Exam Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	How often do you perform a Self-Breast Exam <input type="checkbox"/> Monthly <input type="checkbox"/> Never <input type="checkbox"/> Once a Year <input type="checkbox"/> Several times a Year <input type="checkbox"/> Unknown <input type="checkbox"/> Weekly
Family History of Cancer	
Have any of your relatives been diagnosed with breast, cervical, ovarian, and/or colorectal cancer? <input type="checkbox"/> Yes (Complete information below) <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Relationship:	
<input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Daughter <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle <input type="checkbox"/> Son	
Relation Type: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Age: _____ Cancer Type: <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Ovarian <input type="checkbox"/> Colorectal
Relationship:	
<input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Aunt <input type="checkbox"/> Daughter <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Grandfather <input type="checkbox"/> Uncle <input type="checkbox"/> Son	
Relation Type: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	Age: _____ Cancer Type: <input type="checkbox"/> Breast <input type="checkbox"/> Cervical <input type="checkbox"/> Ovarian <input type="checkbox"/> Colorectal