Florida Breast and Cervical Cancer Early Detection Program

Client Enrollment Form

LAST NAME:		FIRST NAME:		MAIDEN NAME:		DATE OF BIRTH:	

1. APPLICANT INFORMATION (Please complete each section of this application.)

CONTACT INFORMATION

STREET ADDRESS:	
STREET ADDRESS:	
CITY & ZIP CODE:	
EMAIL ADDRESS:	
PRIMARY PHONE:	
ALTERNATE PHONE:	

BEST TIME TO REACH YOU:

☐ A.M. ☐ P.M. ☐ Anytime

☐ Is it okay to leave a message?

PREFERRED APPT. DAY/TIME

HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)

☐ American Cancer Society	☐ Postcard
☐ Brochure	☐ Television
☐ County Health Department	☐ Radio
☐ Community/Health Fair event	☐ Social Media
☐ Family/Friend	☐ Educational Session
☐ Internet/Website	☐ Bus wraps/benches/signs
☐ Private Medical Office	☐ Billboards
☐ Newspaper	Name of Community Health Clinic:
☐ Federally Qualified Health Center	
☐ Other	

SCREENING STATUS (Check only one response.)

☐ Initial (first time in program) ☐ Rescreen (previously in program)

☐ Short-term interval follow-up or repeat exam (less than 300 days from last screening)

Do you have health insurance? ☐ Yes ☐ No

If yes, what is the name of your insurance? ____________

DEMOGRAPHIC INFORMATION

RESIDENTIAL AND CITIZENSHIP STATUS (Check all that apply.)

☐ Florida resident ☐ U.S. Citizen ☐ Citizen in lawful status ☐ Other

ETHNICITY AND RACE IDENTIFICATION (Check all that apply.)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

RACIAL IDENTITY

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

SPOKEN LANGUAGE(S)

Primary language spoken:	
Additional language(s) spoken:	

Language preference to receive mail:

☐ English

☐ Spanish

☐ Creole

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:

LAST NAME: ____ FIRST NAME: ____ MAIDEN NAME: ____ DATE OF BIRTH: ____

2. HEALTH HISTORY

GENERAL HEALTH STATUS (Check all that apply)

- ☐ Diabetes
- ☐ Pre-Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol

HEIGHT (in.): ____ WEIGHT (lbs.): ____

TOBACCO USE (includes vaping, e-cigarettes, and similar products) (Check all that apply)

- ☐ Daily
- ☐ Some days
- ☐ Never/not at all
- ☐ Declined to answer
- ☐ Were you given a referral to Quitline?
- ☐ Declined referral
- ☐ I am interested in quitting.

BREAST EXAM BACKGROUND (Check all that apply)

- ☐ Do you have breast implants?
- ☐ Are you currently experiencing any issues with your breasts? Explain.

____

- ☐ Have you ever been diagnosed with breast cancer?

If you have, what treatment did you receive?

____

When did your treatment end (Month/Year)?

____

When was your last mammogram before enrolling in this program? (Month/Year)

____ ☐ None ☐ Unsured (2+ years)

Where was your last mammogram done? (Provider, City, State)

____

FAMILY HISTORY

Has anyone in your family, such as your mother, sister, brother, or father, been diagnosed with breast cancer? If yes, which relative?

____

CERVICAL EXAM BACKGROUND (Check all that apply)

- ☐ Are you currently experiencing any issues with your cervix? Explain.

____

- ☐ Have you ever been told by a doctor you have invasive cervical cancer?

If you have, what treatment did you receive?

____

When did your treatment end (Month/Year)?

____

When was your last Pap test before enrolling in this program? (Month/Year)

____ ☐ None ☐ Unsured (10+ years)

Where was your last Pap test done? (Provider, City, State)

____

- ☐ Have you ever had a hysterectomy? Specify whether partial or full.
- ☐ Partial hysterectomy (I still have a cervix)
- ☐ Full hysterectomy (no cervix)

What was the reason for the hysterectomy?

____

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