FBCCEDP Program Application

EFFECTIVE: 9/15/2020

Appointment

Date/Time: _____/_____

Type of Appointment (Circle only one):
Screening or Diagnostic

(Attach script or referral here)

Section 1: Applicants Information

SCREENING STATUS: __ INITIAL __ RESCREEN __ SHORT INTERVAL FOLLOW-UP (or REPEAT exam)

NAME (Legal or as it appears on Social Security Card): REQUIRED
Last Name First Name

Middle Name Maiden Name

DATE OF BIRTH: (MM/DD/YYYY)
/ /

STREET ADDRESS (REQUIRED):

ADDRESS:_____

CITY & ZIP CODE:_____

PRIMARY PHONE NO. : ☐ **HOME** ☐ **WORK** ☐ **CELL**

(**)**_____ - _____

ALTERNATIVE PHONE: ☐ **HOME** ☐ **WORK** ☐ **CELL**

(**)**_____ - _____

IS IT OK TO LEAVE A MESSAGE? ☐ Yes ☐ No

BEST TIME TO REACH YOU? ☐ Anytime ☐ AM or ☐ PM

PREFERRED DAY/TIME OF APPOINTMENT?

DAY : _____ AM OR PM

RESIDENTIAL STATUS
Check all that apply: **REQUIRED**

☐ **You must be a Florida Resident to be eligible**

☐ **Underline which applies to you:** US Citizen or under Alien Status

WHAT IS YOUR? REQUIRED

Height ***in inches*****:** _____

Weight ***in pounds*****:** _____

ARE YOU OF LATINO OR HISPANIC ORIGIN? REQUIRED

1. ☐ Yes
2. ☐ No

WHAT LANGUAGES DO YOU SPEAK? REQUIRED

Primary Language:

_____

Other Language:

_____

Do you have a history of Hypertension?

1. ☐ Yes 2. ☐ No

Do you have a history of Diabetes or Pre- Diabetes?

1. ☐ Yes 2. ☐ No

WHAT RACE OR RACES DO YOU CONSIDER YOURSELF?

(Choose all that Apply) **REQUIRED**

1. ☐ American Indian or Alaska Native
2. ☐ Asian
3. ☐ Black or African American
4. ☐ Native Hawaiian or Other Pacific Islander
5. ☐ White

DO YOU USE TOBACCO PRODUCTS? REQUIRED

1. ☐ Daily 2. ☐ Some days 3. ☐ Not at all
4. ☐ Declined to Answer

If 1 or 2, was referred to Quitline? 1. ☐ Yes 2. ☐

******Quitline Phone # 1-877-822-6669******

HOW DID YOU LEARN ABOUT THIS PROGRAM? 1. ☐ Local ACS 2. ☐ Brochure 3. ☐ CHD

4. ☐ Community 5. ☐ Family/Friend 6. ☐ Internet 7. ☐ Medical Office 8. ☐ Newspaper

9. ☐ FQHC 10. ☐ Postcard 11. ☐ Outreach 12. ☐ Television 13. ☐ Radio 14. ☐ Social Media

15. ☐ Educational Session 16. ☐ In-reach 17. ☐ Bus wraps/signs 18. ☐ Billboards

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Section 2: Health History

Breast Exam Background (Check Only One Box For Each Category) **REQUIRED**

Have you ever been diagnosed with BREAST CANCER? ☐ YES ☐ NO

When was your last MAMMOGRAM **before** enrolling in this program?

☐ Last MAMMOGRAM (month_____ /year_____) ☐ NONE ☐ Unsure (5+ years?)

Where was it done? (**PROVIDER**) _____

DO YOU HAVE BREAST IMPLANTS? **1.** ☐ **YES** **2.** ☐ **NO** **PLEASE CHECK ONE**

Cervical Exam Background (Check Only One Box for Each Category) REQUIRED

Have you ever been diagnosed with INVASIVE CERVICAL CANCER? ☐ YES ☐ NO

When was your last PAP SMEAR **before** enrolling in this program?

☐ Last PAP SMEAR exam (month_____ /year_____) ☐ NONE ☐ Unsure (5+ years?)

HYSTERECTOMY? ☐ **YES** ☐ **NO** (☐ **Partial or** ☐ **Full**) **When?** _____ **REQUIRED**

Are you currently experiencing any problems with breast or cervix? ☐ YES ☐ NO

If so, briefly explain _____

If you have any questions, please call (407) 665-3244 or (407) 665-3185 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

FOR PROGRAM OFFICE USE ONLY:

THIS APPLICATION HAS BEEN: ☐ *APPROVED* ☐ *DENIED*

EFFECTIVE: _____ *(MM/DD/YYYY)*