

BCCCP Client Initial Enrollment Form

LCA Name \_\_\_\_\_ Enrollment Site \_\_\_\_\_  
MBCIS ID \_\_\_\_\_ Client ID \_\_\_\_\_ Enrollment Date: \_\_\_\_\_

**Breast & Cervical Cancer Control Program**  
Client Initial Enrollment Form

CLIENT INFORMATION

Social Security Number _____	<b>Last Name</b> _____
<b>First Name</b> _____	MI _____ Maiden Name _____
<b>Birth Date</b> _____	Age _____
Street Address _____	Apt # _____
City _____	<b>County</b> _____ State _____ Zip Code _____
Phone Number _____	Extension _____ Type _____
Method of Contact: <input type="checkbox"/> Write Home <input type="checkbox"/> By Phone <input type="checkbox"/> Other _____	

RACE and ETHNICITY

Are you Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your race and/or ethnicity (mark all that apply)?
Race
<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
Ethnicity (if not listed above)
<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

CONTACT INFORMATION

Please provide the names and contact information of people who could contact you if you moved or changed phone numbers after this visit.

<b>Last Name</b> _____	<b>First Name</b> _____
<b>Relation</b> _____	Primary Contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address _____	Apt # _____
City _____	State _____ Zip Code _____
Phone Number _____	
<b>Last Name</b> _____	<b>First Name</b> _____
<b>Relation</b> _____	Primary Contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address _____	Apt # _____
City _____	State _____ Zip Code _____
Phone Number _____	

BCCCP Client Initial Enrollment Form

LCA Name \_\_\_\_\_ Enrollment Site \_\_\_\_\_ Client ID \_\_\_\_\_

MEDICAL HISTORY

Have you had any of the following cancers (check all that apply)?

Breast  Cervical  Ovarian  Colorectal  Other \_\_\_\_\_

Year Diagnosed: Breast \_\_\_\_\_ Cervical \_\_\_\_\_ Ovarian \_\_\_\_\_

Colorectal \_\_\_\_\_ Other \_\_\_\_\_

Do you smoke (check one)?  Current  Never  Previous

Have you ever had a Pap?  Yes, Exam Date \_\_\_\_\_  No  Unknown

Do you have a history of abnormal Paps?  Yes  No

Have you ever had a Hysterectomy?  Yes, Reason \_\_\_\_\_  No

Do you have a cervix?  Yes  No  Unknown

Have you ever had a Mammogram?  Yes, Exam Date \_\_\_\_\_  No  Unknown

Have you ever had a breast biopsy?  Yes  No

Have you ever had a Clinical Breast Exam?  Yes, Exam Date \_\_\_\_\_  No  Unknown

How often do you perform Breast Self Exams (check one)?

Monthly  Never  Once a year  Several times a year  Weekly

Have any of your relatives ever had breast, cervical, ovarian, and/or colorectal cancer?

Yes  No  Unknown

Relationship:  Mother  Sister  Grandmother  Aunt  Daughter  Father  Brother

Grandfather  Uncle  Son

Relationship is:  Maternal  Paternal  Not Applicable

Age at Diagnosis \_\_\_\_\_ Cancer Type:  Breast  Cervical  Ovarian  Colorectal

Relationship:  Mother  Sister  Grandmother  Aunt  Daughter  Father  Brother

Grandfather  Uncle  Son

Relationship is:  Maternal  Paternal  Not Applicable

Age at Diagnosis \_\_\_\_\_ Cancer Type  Breast  Cervical  Ovarian  Colorectal

DEMOGRAPHICS

Level of Education:  Less than high school  High school graduate  Some college

College graduate

Marital Status:  Married  Never married  Widowed  Divorced  Separated

Employment Status:  Full-time  Not Employed  Part Time  Retired

**Household Income** \_\_\_\_\_ **Household Members** (include yourself) \_\_\_\_\_

Insurance  Yes (copy of front and back of insurance card in permanent medical file)  No

BCCCP Client Initial Enrollment Form

LCA Name \_\_\_\_\_ Enrollment Site \_\_\_\_\_ Client ID \_\_\_\_\_

PROVIDER INFORMATION

Do you have a regular medical provider (doctor/nurse practitioner/clinic)?  Yes  No

If yes, print name and addresses below, if known:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Street Address \_\_\_\_\_ Suite # \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Do you want your test results sent to this provider?  Yes  No

RECENT BREAST CANCER SYMPTOMS

Have you noted any of the following breast cancer symptoms recently?

- Lump  Nipple discharge  Skin changes (dimpling, nipple retraction, scaly skin, etc.)  
 Pain  Other (specify): \_\_\_\_\_

OUTREACH and RECRUITMENT

Why did you make an appointment with our program (check all that apply)?

- Television  
 I learned that the low cost exams were available through this Program  
 I am concerned about my health  
 I think I may have a problem  
 I know that breast and cervical cancer screening tests are important to my health  
 The program offers services that I could not get anywhere else  
 My family or friend wanted me to get this exam  
 Other (specify): \_\_\_\_\_  
 My doctor or nurse recommended it

How did you hear about our program (check all that apply)?

- Article/News in newspaper  
 Ad in newspaper or shopping guide  
 Pamphlet, mail notice, flyer  
 Social group/Church  
 Work  
 Doctor or nurse  
 Community outreach worker (peer advisor/peer educator)  
 Another women screened in this program  
 Other person (e.g. relative, friend)  
 Other (specify): \_\_\_\_\_  
 Radio