**Contact and Demographics**

1. Client Name: Age: Date of Birth:
2. Street Address:
3. Phone #: Best Time to Contact:
4. Sex:                                    MaritalStatus:
5. Email:
6. Emergency Contact:                                         Phone #:                                      Relationship:
7. Education Level:
8. Country of Birth: Primary Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Need Interpreter: **Y / N**
9. Race (*Circle all that apply*): White Black/African American Asian

Native American/Indian Native Hawaiian or Other Pacific Islander

1. Spanish or Latinx:
2. Employment Status:
3. Household size: Gross yearly household income: (*Note: cannot be zero)*
4. How heard of program:                                            Name of referred client and relationship:

**Insurance Status**

(*Circle what applies):*  Not eligible Cannot afford Chose not to enroll Enrolled, but has cost share

Other:

**Health Insurance:** Uninsured

Medicaid (monthly spend down $):                  Medicare Pt. A Medicare Pt. A and B

Private Plan Name and ID:                                                                  Deductible:

Family Planning Benefit Title X (CVR not submitted and exam not covered)

**Healthcare Provider Information**

1. PCP:                                                       Site:                      Phone:                     Fax:
2. Ob/Gyn:                                                     Site:                      Phone:                    Fax:
3. Specialist (Mammo, GI):                                            Site:                      Phone:                         Fax:
4. Appt. Date:

CBE or Pap/Pelvic Colposcopy Mammogram Colonoscopy

**Are you currently experiencing any health issues related to Breast, Cervical or Colon?**

**Screening History**

**Breast:**

1. Previous Mammogram: **Y / N** Date of Mammogram:                           Site
2. Clinical Breast Exam: **Y / N** Date of CBE:                           Site
3. Breast MRI:      **Y / N**      Date of MRI:                           Site

**Cervical:**

1. Previous Pap Test: **Y / N** HR HPV Test: **Y / N** Date of Pap or HR HPV:                    Site
2. Did you have a hysterectomy with cervix removed?: **Y / N**

**Colorectal:**

1. Previous FIT Test: **Y / N** Date Completed:                   Site of FIT Distribution:
2. Previous FOBT Test: **Y / N** Date Completed:                 Site of FOBT Distribution:
3. Sigmoidoscopy past 5 years:  **Y / N** Date of Service:                          Site:
4. Colonoscopy past 10 years: **Y / N** Date of Service:                          Site:
5. Were results normal or abnormal: **Y / N** Recommendation (mm/yr)

**Risk Assessment**

1. Have you had a previous diagnosis of B/C/C:                        Type:                       Age:
2. Parent, sibling or child diagnosed with B/C/C:                   Type:                       Age:
3. More than one grandparent diagnosed with B/C/C:              Type:                       Age:
4. Have you had genetic testing for B/C/C:                                     Date Test Completed:
5. Have you had a biopsy for B/C/C:                                                   Cancer Type:                             Age:
6. Have a personal history of colon or bowel disease, or polyps:
7. Have a family history of colon or bowel disease, or polyps:
8. Age 45 or older and symptomatic for colorectal cancer:                   Symptoms:

**Referred for Services**

Pap and Pelvic Exam: Yes            No            if no, why?

Clinical Breast Exam: Yes            No            if no, why?

Mammogram: Yes            No            if no, why?

Colorectal Exam: Yes            No            if no why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy:             FIT: