Florida HEALTH
Putnam

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

Name of Community Health Clinic: _____

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 ☐

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 ☐ Unsure (5+ years)

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

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 ☐ Unsure (5+ 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?

FAMILY HISTORY

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

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