

**Ohio Department of Health • Ohio Breast and Cervical Cancer Project**

## Client Enrollment and Eligibility

1. Today's date <i>month/day/year</i>	2. Enrollment site		
3. Client's name last	first	<i>MI</i>	<i>maiden</i>

4. Address—Street or PO Box		City	
County		State	Zip
5. Day phone (      )	6. Night phone (      )	7. Date of birth <i>mm/dd/yy</i>	8. Age today  years
9. Social Security number □ □ □   □ □   □ □ □ □	10. Ethnicity <i>check one</i> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino		11. Race <i>check all that apply</i> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian

The information for question number 12 is optional and will be used for program evaluation only.

12. Optional—Are you: <i>check all that apply</i> <input type="checkbox"/> Amish <input type="checkbox"/> Mennonite <input type="checkbox"/> Lesbian <input type="checkbox"/> A woman with a disability
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13. Please let us know about the people who live in your home. a) How many persons are legal dependents? _____ (For example, children under age 18, adults deemed dependent by the court) b) Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, what is your spouse's name? _____
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For the next question, you must list the income of you, your spouse and your legal dependents.

If you live alone, give only your income. Income includes salary and wages, tips, alimony, child support, public assistance, disability, unemployment, Social Security, SSI, interest, retirement fund checks and pension.

14. How much money do you, and members of your household listed above in question 13, make or receive each week (before taxes), month (before taxes) or year (before taxes) from all sources of income?  \$_____ per week   OR   \$_____ per month   OR   \$_____ per year
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15. Which sources of medical coverage do you have now? <i>check all that apply</i> <input type="checkbox"/> No insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Private insurance or HMO <input type="checkbox"/> Other—Disability policy, cancer policy, etc.
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16. How did you hear about the Breast and Cervical Cancer Project for this visit? <i>check one</i> <input type="checkbox"/> My own research <input type="checkbox"/> Friend or relative told me <input type="checkbox"/> Heard about it on the radio, television, or newspaper ad <input type="checkbox"/> BCCP reminder <input type="checkbox"/> My doctor told me
<input type="checkbox"/> Read a brochure, flyer, or poster I got (from)
<input type="checkbox"/> Heard a speaker at (where)
<input type="checkbox"/> Other (describe)

The following questions will help us schedule you for the right test and examinations.

17. Have you recently been told by a medical provider that you have a cervical problem?

Yes  No

18. Have you recently been told by a medical provider that you have a breast problem?

Yes  No

19. Have you ever had a Pap test?

Yes  No

If yes, when and where was your last Pap test? *location*

*mm*                      *dd*                      *yy*  
/                              /                              /

20. Do you have any pelvic symptoms? (bleeding, discharge, pain)

Yes  No

21. Have you ever had cervical cancer?

Yes  No

22. Have you had a hysterectomy (removal of the uterus)?

Yes  No

If yes, give reason

23. Have you ever been told by a medical provider that you have Human Papilloma Virus (HPV) or genital warts?

Yes  No

24. Do you currently smoke?

Yes  No

25. Do any of the following describe you?

Yes  No

- My mother took DES while pregnant with me
- I have HIV or AIDS
- I had cancer of the uterus (womb) or vagina
- I had a pre-cancerous lesion on my cervix
- I have had 5 or more sex partners in my lifetime
- I have bleeding or pain during sex
- I have a new sex partner since my last Pap test
- I had, or have, a sexual disease such as syphilis, gonorrhea or Chlamydia

26. Have you ever had a mammogram?

Yes  No

If yes, when and where was your last mammogram? *location*

*mm*                      *dd*                      *yy*  
/                                      /                                      /

27. Do you have any breast symptoms?  
(lump, change in shape, skin dimpling, discharge, pain)

Yes  No

32. Have any male blood relatives ever had breast cancer?

Yes  No

28. Have you ever had breast cancer?

Yes  No

33. Have you, your mother, sister, daughter, aunt, and/  
or grandmother ever had ovarian cancer?

Yes  No

29. Have you had a mastectomy?

Yes  No

34. Do you have a known BRCA1 or BRCA2 gene mutation?

Yes  No

30. Has your mother, sister or daughter ever had breast  
cancer before she turned 50?

Yes  No

35. Do you have breast implants?

Yes  No

31. Has your grandmother, aunt, niece or half-sister ever had  
breast cancer before she turned 40?

Yes  No

36. What is the best time of day for your appointments?

Empty text box for answer.

37. Who is your doctor?

Name of doctor or clinic	Phone (                      )
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38. Will you need any assistance once you arrive at your appointment?

Yes  No

If yes, describe.

39. If BCCP staff can not reach you by mail or phone, BCCP staff may contact the following persons for the purpose of obtaining your current address or phone number. Please provide names and telephone numbers of two people who can always reach you.

Name	Name
Relationship	Relationship
Phone (                      )	Phone (                      )

**Thank you for completing this form!**

**For Office Use Only**

40 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within 200% of Federal Poverty Level? <input type="checkbox"/> Yes <input type="checkbox"/> No
Uninsured? <input type="checkbox"/> Yes <input type="checkbox"/> No	<ul style="list-style-type: none"> <li>• If any "No" answers are indicated, woman is not eligible for BCCP.</li> <li>• If woman is eligible, entire form must be completed.</li> </ul>