Cancer Services Program of Monroe County **Facility Name: ______________________**

Breast, Cervical and Colorectal Cancer Screening Enrollment Form

New Enrollee: ________ or Return Patient: ____________________________ Date of Birth: _______________
Client ID # (if applicable)

____
Last Name First Name Middle Initial Maiden Name (if applicable)

____
Street Address City Zip County

( ) ________________________________ ( ) ________________________________
Phone number Alternate number Best time to contact

____________________________________ ____________________________________
Email address Employer

____________________________________ ____________________________________
Social Security # (can be refused) Country of Birth

Sex: ☐ Female ☐ Male Spanish or Latino: ☐ Yes ☐ No ☐ Unknown

Race: (Check all that apply): ☐ White ☐ Black/African American ☐ Native American/Indian
☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Household size: _______ Gross Monthly Household income: _________________ (***Note: cannot be zero or left blank***)

______________________________ ( ) ____
Emergency Contact Phone number Relationship

____
How did you hear about this program (please be specific)

(to be completed by clinical staff)

Health Insurance: ☐ Uninsured

☐ Medicaid (Monthly spend down $ _____________) ☐ Medicare (Part A only ____ Part A& B _________)

☐ Private Deductible $_______ I.D.#__________________ Plan Name________________________________)

☐ Family Planning Benefit ☐ Title X (CVR not submitted & Exam not covered)

____ ( ) _________
Doctor (GYN, PCP, etc.) Address/Practice Phone number

____ ( ) _________
Specialist (Mammo, GI, etc.) Address/Practice Phone number

Date of appointment: __________________________ __________________________
CBE / Pap & Pelvic Mammogram

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Patient's name: ______________________________________ Date of birth: ____________________________

SCREENING HISTORY:

Previous Mammogram: Yes___ No ___ Unknown___ Where________________ Date _________ (mm/year)

Previous (CBE): Yes___ No ___ Unknown___ Where________________ Date _________ (mm/year)

Previous Pap Test: Yes___ No ___ Unknown___ Where________________ Date _________ (mm/year)

Have you had a hysterectomy with cervix removed? Yes___ No____ Unknown___

At-home stool test in the past 12 months: Yes___ No ___ Under 50___ Test type: FIT ____ FOBT ____

Sigmoidoscopy in the last 5 years: Yes___ No ___ Unknown___ Where________________ Date _________ (mm/year)

Colonoscopy in the last 10 years: Yes___ No ___ Unknown___ Where________________ Date _________ (mm/year)

RISK STATUS for Breast, Cervical or Colorectal (B/C/C) cancer:

Have you had a previous diagnosis of B/C/C: Yes___ No ___ Which one__________ At what age______

Parent, brother, sister, or child diagnosed with B/C/C: Yes___ No ___ Which one__________ At what age______

More than one grandparent, aunt or uncle with B/C/C: Yes___ No ___ Which one__________ At what age______

Family member diagnosed with ovarian cancer: Yes___ No ___ At what age______

Have you had genetic testing for B/C/C: Yes___ No ___ Which one__________ At what age______

Ever had a biopsy for B/C/C: Yes___ No ___ Which one__________ At what age______

Personal history of colon or bowel disease, or polyps: Yes___ No ___ Which one__________ At what age______

Family history of colon or bowel disease, or polyps: Yes___ No ___ Which one__________ At what age______

Age 50 or older & symptoms of significant bowel or colon problems such as bleeding, mass, or bowel changes Yes___ No ___

Do you smoke? Yes___ No ___

REFERRED FOR SERVICES: (Provider- please indicate the services that this patient needs.)

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 _______ Colonoscopy: _______ FIT: _______