

draft - ENROLLMENT FORM - draft

Connecticut Early Detection Programs

(Page 1)

Med-IT # []

Chart # []

Enrollment

Enrolling Provider

[]

Region:

[]

Date Enrolled:

[mm/dd/yyyy]

Pending: Yes No

Status:

[]

As of:

[mm/dd/yyyy]

Contact Information

Name: [] [] [] [Last Name, First Name, MI]

Gender: Male Female

Maiden Name: []

SSN: []

Address: []

Address 2: []

Date of Birth: [mm/dd/yyyy]

Zip Code: []

City: []

State: []

County: []

Home Phone: []

Cell Phone: []

Work Phone: []

Eligibility

Household Income Before Taxes: []

Income Frequency: []

People living on this income: []

__weekly __monthly __yearly

Insurance: Yes Private Medicaid SAGA No Not Enough Deductible High Coverage Low

Medical Consent / Medical Release form signed: Yes No Unknown

Eligibility Level: []

Culture

Country of Birth: []

Race: White

Asian

Hispanic: Yes No Unknown

Yes, Cuban

Yes, Mexican

Yes, Puerto Rican

Yes, South or Central American

Yes, Other Spanish culture or origin, regardless of race, specify:

[]

Asian Indian

Korean

Chinese

Taiwanese

Filipino

Vietnamese

Japanese

Other Asian, specify:

[]

Native American / Alaskan Native

Black / African American

Native Hawaiian or Other Pacific Islander

Guamanian or Chamorro

Samoan

Other Pacific Islander, specify:

[]

Haitian: Yes No Unknown

Alternate Contact Information

Name: []

Relation: []

Address: []

Address 2: []

Zip Code: []

City: []

State: []

Home Phone: []

Cell Phone: []

Work Phone: []

draft - ENROLLMENT FORM - draft

Connecticut Early Detection Programs

Med-IT #:

Chart #:

Client Information

(Page 2)

Name:
 [Last Name, First Name, MI]

Date of Enrollment:
 [mm/dd/yyyy]

Demographics

How well do you speak English? Very Well Well Not Well Not at all

In what language do you prefer to read health information?

In what language do you prefer to hear about health information?

When did you come to live in the United States? [mm/dd/yyyy]

Employment Status? Employed for Wages Out of work > 1 year Homemaker Retired
 Self-employed Out of work < 1 year Student Other, specify:

How did you learn about the program?
 Friend / Family Member State Health Department / Website Mailing / Coupon
 Church Local Health Department / Website Television/Radio
 Social Group Women's Services / Outreach Worker Newspaper
 Work Family Doctor / Clinic Brochure / Poster

What is the highest grade or level of school you have completed?

Breast Health History

Prior Mammogram? Yes No

Date of Prior Mammogram:
 [mm/dd/yyyy]

Result of Prior Mammogram: Normal Abnormal Don't Remember

Please select all that apply:

<input type="checkbox"/> Personal history of breast cancer	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> Personal history of pre-malignant biopsy	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> Mother, sister or daughter with breast cancer	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> First pregnancy after age 30	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> Ever taken estrogen for birth control	How many years? <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> Ever taken estrogen hormone replacement therapy (HRT)	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> Post menopause	at age <input type="text"/>	(leave blank if unknown)

Cervical Health History

Prior Pap Test? Yes No

Date of prior Pap test: [mm/dd/yyyy]

Result of prior Pap test: Normal Abnormal Don't Remember

Have you ever had a hysterectomy? Yes No Was the hysterectomy due to cancer? Yes No

Please select all that apply:

<input type="checkbox"/> First intercourse before age 16	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> More than 1 sexual partner in lifetime	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> History of sexually transmitted disease (STD)	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> History of abnormal Pap results	at age <input type="text"/>	(leave blank if unknown)
<input type="checkbox"/> Current Smoker <input type="radio"/> Sometimes <input type="radio"/> Every day	at age <input type="text"/>	(leave blank if unknown)