Montgomery County Cancer and Tobacco Prevention Program Application

(Revised: 09/30/19
Effective01/08/2020)

Are you interested in Breast/Cervical Cancer Screening and/or Colon Cancer Screening?

☐Breast and Cervical ☐Colon ☐Both ☐Patient Navigation

Patient Information:

Last Name: _____**Suffix:**_____**First Name**: _____**Middle Initial**: ____
(Jr., Etc.)

Date of Birth____/____/____ **Age** _____**Social Security Number:** _____

Street Address: _____**Apartment/Room/Unit#:**_____

City_____**County**:_____**State**_____**Zip code:** _____

Telephone: Home (_____) _____-_____**Work** (_____) _____-_____**Cell** (_____) _____-_____

Best number to call_____

Email: ☐Yes ☐No **Email Address**: _____

Text: ☐Yes ☐No **Number:** _____

Gender: ☐Male ☐Female

Ethnicity: ☐Black Latina/Hispanic ☐White Latina/Hispanic ☐Non-Hispanic ☐Unknown

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American
(check all
that apply) ☐Hawaiian/Other Pacific Islander ☐White/Caucasian ☐Unknown ☐Other, specify_____

Education level: ☐No high school ☐Some high School ☐High school graduate
(Highest Level)
☐Greater than high school ☐Unknown

Marital Status: ☐Married ☐Divorced ☐Widowed ☐Separated ☐Never married
☐Partner of an unmarried couple ☐Unknown
If married, spouse's full name_____

Primary/preferred language: ☐English ☐Spanish ☐French ☐Chinese ☐Other, specify_____

Country of Birth: _____

Will you need an interpreter? ☐Yes ☐No If yes, in what language: _____

Do you have any needs or disabilities of which we should be aware? ☐No
☐Yes, check all that apply from the list below:
☐Hearing impairment ☐Speech Impairment ☐Learning Disability ☐Physical Disability
☐Handicap Access ☐Child care/Elder care ☐Need help making appointments
☐Transportation ☐Other, Specify_____

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Emergency Contact Information (person to contact if we cannot reach you)

Last Name_____First Name_____Relationship to you: _____

Telephone: Home (_____) _____-_____Work (_____) _____-_____Cell_ (_____) _____-_____

Household Information

Number of persons in household :_____(including self, your spouse and any dependents)
Annual Income: $_____ (Income includes: employment, social security, disability, unemployment, investment income, etc. If you are married, you must include your husband's salary.)
If no income, explain how you are supported: _____

Health Care Provider/Doctor/Clinic and Health Insurance Information

Do you have a health care provider/doctor/Clinic: ☐Yes ☐No/Unknown

Health Care provider/Doctor/Clinic name_____

Where/Location: _____

Health Care Provider/Doctor/Clinic telephone number :(_____) _____-_____

Patient Navigator_____Phone:_____ Fax: _____

Email address: _____

Are you covered by health insurance: ☐Yes ☐No ☐Unknown
If yes, type of health insurance:
☐Medicare- Type A ☐ Medicare- Types A and B ☐ Medicare- Type unknown ☐Medicaid/Medical Assistance
☐Private/Commercial (HMO/PPO) ☐PAC ☐Other
If yes, you must attach a copy of the front and back of your insurance card to this form.

How did you learn of this screening program? (check all that apply)
☐Community Event ☐Other Healthcare Provider ☐Doctor ☐Friend ☐Family ☐Mailing
☐Billboard ☐Church ☐Community Event ☐Magazine article ☐Brochure ☐Newspaper
☐Social Media ☐Poster ☐Television ☐Internet ☐Radio ☐Unknown
☐Community Agency, specify: _____

☐Local Program (other than Cancer and Tobacco Program), specify: _____

☐Other, specify: _____

Have you ever been screened or treated for colon, oral, skin, prostate, breast or cervical cancer by any Maryland Public Health Program? ☐No ☐Unknown

☐Yes, specify county(s):_____

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Personal Medical History

Do you have or ever had any of the following illnesses/conditions: (check all that apply)

Allergies: ☐Yes ☐No ☐Unknown
Diabetes: ☐Yes ☐No ☐Unknown
High blood sugar: ☐Yes ☐No ☐Unknown
Heart Disease: ☐Yes ☐No ☐Unknown
High blood pressure: ☐Yes ☐No ☐Unknown
Kidney problems: ☐Yes ☐No ☐Unknown
Lung disease: ☐Yes ☐No ☐Unknown
Other: ☐Yes ☐No ☐Unknown
If yes, kind/type of illness/condition:_____

Any kind/type of cancer: ☐Yes ☐No ☐Unknown
(do not include breast/cervical/colon)
If yes, kind/type of cancer:_____
Date of diagnosis:_____
Any kind/type of surgery: ☐Yes ☐No ☐Unknown
If yes, kind/type of surgery:_____

Have you ever used tobacco in any form?
☐Yes (continue this section) ☐No (stop) ☐Unknown (stop)
Do you currently use tobacco? ☐Yes ☐No ☐Unknown
If yes, check all products used:
☐Cigarette ☐Pipe ☐Cigar ☐Spit tobacco (snuff, chewing, etc.)
Have you smoked 100 or more cigarettes over your lifetime?
☐Yes ☐No (stop) ☐Unknown
If yes, at what age did you first smoke?
Age:_____ ☐Unknown
If you quit smoking, at what age did you quit?
Age:_____ ☐Unknown
Average number of packs of cigarettes you smoke(d) each day (20 cigarettes per pack):_____
Medications: (list any you currently taking)
_____ _____
_____ _____

Colon Personal and Family History; Colon Cancer Screening Test

Interested in colon cancer screening: ☐No (go to next section)
☐Yes (check all that apply in this section)

Do you have or ever had any of the following illnesses/conditions: (check all that apply)

Colorectal Cancer: ☐Yes ☐No ☐Unknown
If yes, date of diagnosis: _____
Colorectal polyp: ☐Yes ☐No ☐Unknown
If yes, date of first diagnosis: _____
History of Inflammatory Bowel Disease: ☐Yes ☐No ☐Unknown
Pelvic Radiation: ☐Yes ☐No ☐Unknown

Have you had any of the following symptoms? (check all that apply)

Lower abdominal pain: ☐Yes ☐No If yes, for how long? _____
Bright red blood per rectum, bloody stools: ☐Yes ☐No
Marked change in bowel habits ☐Yes ☐No
Unexplained weight loss: ☐Yes ☐No If yes, for how long? _____
Other gastrointestinal symptoms: _____

Has anyone one in your family (first – degree relative) have any of the following conditions:

Cancer of the colon: ☐Yes, specify relationship and youngest age at diagnosis ☐No ☐Unknown
☐Father- Age_____ ☐Mother- Age_____☐Brother- Age_____☐Sister- Age_____
☐Son- Age_____☐Daughter- Age_____Other (specify):_____- Age_____
Colon Adenoma/Serrated Polyp/Polyp Type Unknown:
☐Yes, specify relationship and youngest age at diagnosis ☐No ☐Unknown
☐Father- Age_____ ☐Mother- Age_____☐Brother- Age_____☐Sister- Age_____
☐Son- Age_____☐Daughter- Age_____Other (specify):_____- Age_____

Have you been previously screened for colorectal cancer? ☐Yes (check all that apply) ☐No ☐Unknown

☐Sigmoidoscopy Date_____Where_____Results_____

☐Colonoscopy Date_____Where_____Results_____

☐Barium Enema Date_____Where_____Results_____

Other Test (specify): _____Date_____Where_____Results_____

Breast Personal and Family History; Breast Cancer Screening Test

Interested in breast cancer screening: ☐No (Go to next Section)

☐Yes (check all that apply in this Section)

Do you have or ever had any of the following illnesses/conditions: (check all that apply)

Breast Cancer: ☐Yes ☐No ☐Unknown

If yes, date of first diagnosis: _____

Surgery on either breast: ☐Yes ☐No ☐Unknown

If yes, date: _____ Why? _____

Breast Implants: ☐Yes ☐No ☐Unknown

Have you had any of the following symptoms? (check all that apply)

Breast Pain ☐Yes ☐No ☐Unknown

Breast Problems (lump, bleeding or discharge from nipples): ☐Yes ☐No ☐Unknown

Has anyone one in your family (first – degree relative) have any of the following conditions:

Breast Cancer: ☐Yes, specify relationship and youngest age at diagnosis ☐No ☐Unknown

☐Father- Age_____ ☐Mother- Age_____☐Brother- Age_____☐Sister- Age_____

☐Son- Age_____☐Daughter- Age_____Other (specify):_____- Age_____

Have you been previously screened for breast cancer? ☐Yes (check all that apply) ☐No ☐Unknown

☐Breast Exam by doctor Date_____Where_____Results_____

☐Mammogram Date_____Where_____Results_____

Cervical Personal and Family History; Cervical Cancer Screening Test

Interested in cervical cancer screening: ☐No (Go to next Section)

☐Yes (check all that apply in this Section)

Do you have or ever had any of the following illnesses/conditions: (check all that apply)

Cervical Cancer: ☐Yes ☐No ☐Unknown

Hysterectomy: ☐Yes ☐No ☐Unknown

If yes, date: _____ Why? _____

Cervix: ☐Yes ☐No ☐Unknown

Menstrual period: ☐Yes ☐No ☐Unknown If yes, date of last menstrual period: _____

Have you had any of the following symptoms? (check all that apply)

Abnormal Vaginal Bleeding or Abnormal Vaginal Discharge ☐Yes ☐No ☐Unknown

Pelvic Pain ☐Yes ☐No ☐Unknown

Has anyone one in your family (first – degree relative) have any of the following conditions:

Cervical Cancer: ☐Yes, specify relationship and youngest age at diagnosis ☐No ☐Unknown

☐Father- Age_____ ☐Mother- Age_____☐Brother- Age_____☐Sister- Age_____

☐Son- Age_____☐Daughter- Age_____Other (specify):_____- Age_____

Have you been previously screened for cervical cancer? ☐Yes (check all that apply) ☐No ☐Unknown

☐Pap Test Date_____Where_____Results_____

☐Pap/HPV Test Date_____Where_____Results_____

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Appointment Information

The best days and times for your appointment

Monday: ☐AM ☐PM Tuesday: ☐AM ☐PM Wednesday: ☐AM ☐PM

Thursday: ☐AM ☐PM Friday: ☐AM ☐PM Comments: _____

My signature below affirms that the information provided here is true to the best of my knowledge. I understand that knowingly providing false information may result in my discharge from the program.

Signature: _____**Date:**_____

Program/Office Use Only

Provided literature/info. to client on dangers of tobacco use:	□ Yes	□ No

Is client eligible for any cancer screening, diagnosis or treatment services in the Program?

□ **Yes, enroll client in the following CDB module** ***(check all that apply)***

□ **Colorectal**

□ **Yes, enroll client in the following CaST module** ***(check all that apply, must select at least one)***

□ **Breast** □ **Cervical**

□ **Approved NCM Signature:**_____**Date:**_____

□ **No** [*Do not enter client in CDB/CaST*]

Not eligible: Reason:_____