

## Core Demographic Screening Form

<b>Program Use Only</b>		<b>Client Identification</b>	
<b>Jurisdiction:</b> _____  Interviewer: _____  <b>Interview Date:</b> _____ / ____ / ____ (mm/dd/yyyy) <b>Enrollment Date:</b> _____ / ____ / ____ (mm/dd/yyyy)	<b>CDB ID:</b> (system generated) _____  <b>Local ID:</b> (optional) _____  <b>Date of Data Entry into CDB:</b> (mm/dd/yyyy) ____ / ____ / ____  <div style="text-align: right;"><i>Initials:</i> _____</div>		

<b>Patient Information</b>			
<b>Last Name:</b> _____	Suffix: _____ (Jr., etc.)	<b>First Name:</b> _____	Middle: _____
<b>Date of Birth:</b> _____ / ____ / ____ (mm/dd/yyyy)	Age at Enrollment: _____	<b>SSN:</b> _____ (last 4 digits)	
<b>Residential Address</b>	<b>Street Address:</b> _____		Apartment/Room/Unit #: _____
	<b>City:</b> _____	<b>County:</b> _____	<b>State:</b> _____
Telephone: Home ( ) - Work ( ) - Cell ( ) -			
<b>Is mailing address different from residential address?</b> <input type="checkbox"/> Yes (Enter information below) <input type="checkbox"/> No (Go to next section)			
<b>Mailing Address</b>	<b>Street Address:</b> _____		Apartment/Room/Unit #: _____
	<b>City:</b> _____	<b>State:</b> _____	<b>Zipcode:</b> _____

<b>Contact Information (person to contact if we cannot reach you)</b>		
Last Name: _____	First Name: _____	Relationship: _____
Street Address: _____		Apartment/Room/Unit #: _____
City: _____	State: _____	Zipcode: _____
Telephone: Home ( ) - Cell: ( ) -		

<b>Learn of Program</b>
How did you learn of this screening program? <i>(check all that apply)</i>
<input type="checkbox"/> Billboard <input type="checkbox"/> Breast and Cervical Cancer Program <input type="checkbox"/> Brochure <input type="checkbox"/> Church <input type="checkbox"/> Community Event <input type="checkbox"/> Doctor <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Magazine article <input type="checkbox"/> Mailing <input type="checkbox"/> Newspaper <input type="checkbox"/> Other Health Care Provider <input type="checkbox"/> Poster <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Unknown
<input type="checkbox"/> Community Agency, specify: _____
<input type="checkbox"/> Local Program (other than BCCP), specify: _____
<input type="checkbox"/> Other, specify: _____
Comments

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<b>Client Name (Last, First):</b>	<b>ID:</b>
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<b>Gender:</b>	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Unknown
<b>Ethnicity (Hispanic or Latino):</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Race:</b> <i>(check all that apply)</i>	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American
	<input type="checkbox"/> Hawaiian/Other Pacific Islander	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Unknown
<b>Education:</b> <i>(highest level)</i>	<input type="checkbox"/> No high school	<input type="checkbox"/> Some high school	<input type="checkbox"/> High school graduate
	<input type="checkbox"/> Greater than high school	<input type="checkbox"/> Unknown	
<b>Marital Status:</b>	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
	<input type="checkbox"/> Never married	<input type="checkbox"/> Partner of an unmarried couple	<input type="checkbox"/> Separated
<b>Primary Language:</b>	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese
	<input type="checkbox"/> Korean	<input type="checkbox"/> Other, specify:	
<b>Is an interpreter needed?</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Do you have any needs or disabilities of which we should be aware?			<input type="checkbox"/> No
<input type="checkbox"/> Yes, check all that apply from the list below:			
<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Speech Impairment	<input type="checkbox"/> Learning Disability	
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Handicap Access	<input type="checkbox"/> Child care/Elder care	
<input type="checkbox"/> Need help making appointments	<input type="checkbox"/> Transportation		
<input type="checkbox"/> Other, specify:			
<b>Household Info:</b>	Annual income: \$	Income documentation: <input type="checkbox"/> Verbal <input type="checkbox"/> Written	
	Number of persons in household, including self:		

<b>Previous Enrollment</b>
<b>Have you ever been screened or treated for colon, oral, skin, or prostate cancer by any Maryland Public Health Program?</b> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, specify county(s):
Have you ever been screened for breast or cervical cancer by the Breast and Cervical Cancer Program (BCCP)? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Health Care Provider and Insurance Information</b>
<b>Do you have a primary health care provider?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
If yes, identify provider (last name, first name) or practice:
Street Address: <span style="float: right;">Suite:</span>
City: <span style="margin-left: 100px;">State:</span> <span style="margin-left: 100px;">Zipcode:</span> <span style="float: right;">Telephone: (    )    -</span>
<b>Are you covered by health insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, type of <i>primary</i> health insurance:
<input type="checkbox"/> Medicare–Type A <input type="checkbox"/> Medicare–Types A and B <input type="checkbox"/> Medicare–Type unknown
<input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> Other
<input type="checkbox"/> PAC
Name and policy number of <i>primary</i> health insurer:
Type of <i>secondary</i> health insurance, if any:
<input type="checkbox"/> Medicare–Type A <input type="checkbox"/> Medicare–Types A and B <input type="checkbox"/> Medicare–Type unknown
<input type="checkbox"/> Medicaid <input type="checkbox"/> Commercial <input type="checkbox"/> Other
<input type="checkbox"/> PAC
Name and policy number of <i>secondary</i> health insurer, if any:

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### Health History

**Do you have a history of any kind of cancer?**     Yes     No     Unknown

If yes, specify the type, date, and details in the following table:

Type of Cancer	Date of Diagnosis	Treatment Details

Have you had any of the following illnesses/conditions? Check all that apply and provide details:

- Allergies, details: \_\_\_\_\_
- Diabetes, details: \_\_\_\_\_
- Disabilities, details: \_\_\_\_\_
- Heart disease, details: \_\_\_\_\_
- High blood pressure, details: \_\_\_\_\_
- Kidney problems, details: \_\_\_\_\_
- Lung disease, details: \_\_\_\_\_
- Other illness/condition, details: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

**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): \_\_\_\_\_

### Program Use Only

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

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

- No (*Do not enter client in CDB*)
- Yes, enroll client in the following module (*check all that apply, must select at least one*)
  - Colorectal                       Prostate                       Oral                       Skin

### Comments: