

Breast and Cervical Cancer Early Detection Program - Virginia Department of Health

Office Use Only

Administrative Site: UVA Case Manager: Elizabeth Banning Enrollment Date: ___ / ___ / ___

Enrollment Site: _____ Client Status: Active – check one: New Patient Rescreen Client ID _____

Inactive due to: (list reason) _____ Effective Date _____

How did you hear about the Every Woman's Life Program? Community Health Worker Brochure
 Radio/TV/Newspaper Family/Friend Doctor/Clinic Internet/Web Health Dept Other

Last Name _____ First Name _____ Maiden Name _____ Middle Initial _____

Social Security # _____ - _____ - _____ Birth Date _____ / _____ / _____ Age _____

Address _____

City _____ County _____ State _____ Zip _____

Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

Do you have an answering machine? Yes No - If NO, please list a contact with a phone number that we may contact. NAME _____ RELATION _____ PHONE _____

Are you interested in receiving a monthly reminder via email to do your monthly self breast exam?
 No Yes / List your Email Address (please print clearly) _____

Marital status: Married Divorced Widowed Separated Never Married (single) Member of an unmarried couple

Number of years of education? (Circle one) 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

Do you describe yourself as: (check all that apply)

American Indian/Alaskan Native Asian (or Indian) Black/African American Native Hawaiian or Pacific Islander White

Are you Spanish, Hispanic, or Latina?..... No Yes

What language do you speak every day? _____

Do you need an interpreter to accompany you during health exams? No Yes

If YES, what language/dialect should they speak? _____

What is your annual household income before taxes? \$ _____ Monthly Yearly

How many people live on this income? _____ (1 if just yourself - otherwise total number living in household)

Do you have any of the following? (Check yes or no for each)

Medicaid? No Yes

Medicare? No Yes (If yes, do you have Part A, Part B, or Both A&B)

Private Insurance? No Yes (If Yes what is your deductible \$ _____ has it been paid this year? No Yes

Name of your Primary Care physician _____ **Phone** (____) ____ - ____

SCREENING HISTORY BREAST:

Do you check your own breasts for lumps (breast self-exam)?..... No Yes

If **YES**, how often? Every month Every other month Less than every other month

Do you currently have breast symptoms? No Yes

If **YES**, describe Left-side Right-side Both Breasts

Check all symptoms you have Lump Pain Discharge Dimpling Scaling Retraction

Have you ever had a clinical breast exam? No Yes

If **YES**, date of last breast exam (mm/yy) _____/_____. Provider: UVA MJH Other
(A clinical breast exam is when a doctor, nurse, or other health professional feels the breast for lumps)

Have you ever had a mammogram? No Yes

If **YES**, date of last mammogram (mm/yy) _____/_____. Provider: UVA MJH Other

If you have never had a mammogram or not had one in the last two years, what was the most important reason that you did not have one:

- | | |
|---|---|
| <input type="checkbox"/> Was not recommended by doctor | <input type="checkbox"/> Cost |
| <input type="checkbox"/> I felt it was not needed/not necessary | <input type="checkbox"/> No insurance/Insurance does not pay for it |
| <input type="checkbox"/> Never heard of mammogram | <input type="checkbox"/> Fear, worry, embarrassment |

HEALTH HISTORY: (PLEASE CHECK NO OR YES FOR EACH QUESTION)

Has your mother, sister, daughter or other blood related female relative ever had breast cancer? No Yes

Relationship _____ Age diagnosed _____

Relationship _____ Age diagnosed _____

Relationship _____ Age diagnosed _____

Have you ever had breast cancer? No Yes

If **YES**, when? (mm/yy) _____/_____. **What type of treatment?** _____

Lumpectomy Mastectomy Chemotherapy Radiation Other: _____

Have you ever had a mastectomy (removal of the breast)? No Yes

Left Breast Right Breast Both Breasts Date: (mm/yr) _____/_____

Have you ever had a lumpectomy (removal of a breast lump)? No Yes

Left Breast Right Breast Both Breasts Date: (mm/yr) _____/_____

Do you have breast implants? No Yes

Left Breast Right Breast Both Breasts Date: (mm/yr) _____/_____

SCREENING HISTORY CERVICAL:

Have you ever had a Pap test? No Yes

Date of last Pap test: (mm/yr) ____/____

Provider: UVA MJH Other

*If you have **never** had a pap test **or** have not had one in the **last two years**, what was the most important reason that you did not have one:*

- Was not recommended by doctor
- I felt it was not needed/not necessary
- Never heard of Pap test
- Cost
- No insurance/Insurance does not pay for it
- Fear, worry, embarrassment

Have you ever had an abnormal Pap test? No Yes

Have you ever had cervical cancer? No Yes

If YES, when? (mm/yy) ____/____

What type of treatment? LEEP Cone Other: _____

Have you ever had a hysterectomy? (removal of the uterus/womb) No Yes

If YES, at what age? _____ Was it for cancer or an abnormal Pap test? No Yes

Use of hormone replacement pills/patch? Use now Used in past Never used

If used (now or in past) how many years total have you used? _____ (number of years)

If used less than 1 year check here and enter number of months _____ (number of months)

Have you ever used birth control pills/patch? No Yes

If used (now or in past) how many years total have you used? _____ (number of years)

If used less than 1 year check here and enter number of months _____ (number of months)

Smoke cigarettes? Smoke now Used to smoke Never smoked

Date of your last menstrual period? (If post-menopausal list year) (dd/mm/yy) ____/____/____

How old were you when you began your first menstrual period? _____ (age)

Have you ever been pregnant? No Yes

If YES, age at first pregnancy? _____ (age)

Total Number of Pregnancies: (include abortions/live & still births) _____

**EVERY WOMAN'S LIFE
APPOINTMENT CHOICES FORM**

Patient's First Name: _____ Patient's Last Name _____

Please choose only one provider

University of Virginia as my Provider (check one box only)

UVA Cancer Center (Thursdays)-

UVA Northridge

University Physicians of Orange

Choose a provider from above OR below (not both)

Martha Jefferson Medical Services as my Provider (check one box for your provider)

MJ Afton Family Medicine MJ Blue Ridge Internal Medicine MJ Buckingham Family Med

Charlottesville FREE CLINIC (Tuesday & Thursday appointments) MJ Crozet Family Medicine Downtown Family Healthcare

MJ Forest Lakes Family Med Fluvanna Family Medicine Fork Union Medical Associates

MJ Greene Family Medicine MJ Madison Family Medicine Orange Family Physicians (Monday appointments)

MJ Palmyra Internal Medicine River's Edge Family Medicine

What days of the week are you available for exams? Please check all that apply to allow flexibility when scheduling.

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What time of day are you available for your exams? Please check all that apply.

Morning	8:00 am <input type="checkbox"/>	8:30 am <input type="checkbox"/>	9:00 am <input type="checkbox"/>	9:30 am <input type="checkbox"/>	10:00 am <input type="checkbox"/>	10:30 am <input type="checkbox"/>	11:00 am <input type="checkbox"/>	11:30 am <input type="checkbox"/>	Anytime in the Morning <input type="checkbox"/>
Midday	12:00 N <input type="checkbox"/>	12:30 pm <input type="checkbox"/>	1:00 pm <input type="checkbox"/>	1:30 pm <input type="checkbox"/>	Anytime Midday <input type="checkbox"/>				
Afternoon	2:00 pm <input type="checkbox"/>	2:30 pm <input type="checkbox"/>	3:00 pm <input type="checkbox"/>	3:30 pm <input type="checkbox"/>	Anytime in the Afternoon <input type="checkbox"/>				

Please list ALL dates in the next 2 months when you will NOT be available:

Dates: _____
