BCCCNP
Breast and Cervical Cancer
Control Navigation Program

BCCCNP Enrollment Form

To be completed by Clinic Staff:
☐ Initial Exam
☐ Annual Exam

Enrollment Site or Clinic Name: Date:

Client Contact Information – Please PRINT

Last Name		**First Name**		M.I.	
Social Security #					
Maiden Name		**Birth Date**		**Age**	
Street Address		**Apt.**		**City**	
PO Box		**State**		**Zip Code**	
County		Addl. Address			
Phone Number ( ) -		Ext		☐ Day ☐ Evening ☐ Home ☐ Work ☐ Pager ☐ Fax ☐ Cell	

Race and Ethnicity

Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander ☐ Unspecified ☐ American Indian/Alaskan Native

Ethnicity – mark all that apply: ☐ European ☐ Middle Eastern, North African, Arab
☐ African, Caribbean Islander ☐ Spaniard, Mexican, Central, South, or Latin American Puerto Rican, Cuban
☐ Canadian / Latin American Indian ☐ Canadian/Latin American Indian ☐ Unknown

Demographics	**Household Members & Income** **MUST** be complete to ensure payment
Marital Status: ☐ Married ☐ Never married ☐ Widowed ☐ Divorced ☐ Separated	
Level of Education: ☐ Less than high school ☐ High school graduate ☐ Some college ☐ College graduate	**Number of people in the household** (including yourself):
Employment Status: ☐ Full-time ☐ Not Employed ☐ Part Time ☐ Retired	**Gross Yearly Income: $**

Provider (Primary Care) Information

Do you have a regular Primary Care Provider (doctor/nurse practitioner/clinic)? ☐ Yes - fill out information below ☐ No

Do you want your test results sent to this provider? ☐ Yes ☐ No

Physician Name:	Physician Address:

Alternate Contact Information

Name:	**Is this person a:** ☐ Spouse ☐ Child ☐ Friend ☐ Neighbor ☐ Relative ☐ Other ________________
Phone Number: ( ) -	

INSURANCE INFORMATION (bring *ALL* cards with you)

Provider: Please fax copy of card to BCCCP & retain in patient medical record.

☐ None

☐ Medicaid # ______________________________

☐ Medicare Part A Only # ____________________

☐ County Health Plan HPMS __________________

☐ Blue Cross ______________________________
Contract # Group #

☐ Other __________________________________
Contract # Group #

Reviewed by: ______________________ RN

______________________ FNP

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MEDICAL HISTORY

Recent breast symptoms

☐ Lump ☐ Nipple Discharge ☐ Skin Changes (dimpling, nipple retraction, scaly skin, etc.)
☐ Pain ☐ Other (specify): ______________________________

Smoking/Alcohol History

Do you smoke cigarettes? ☐ Every day ☐ Most days ☐ Not at all

Are you interested in quitting smoking? ☐ Yes ☐ No ☐ I do not smoke

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ______

Personal Cancer History

☐ Breast	☐ Cervical	☐ Colorectal	☐ Ovarian	☐ Other: ______________
_______ Yr Diagnosed	_______ Yr Diagnosed	_______ Yr Diagnosed	_______ Yr Diagnosed	_______ Yr Diagnosed

Breast and Cervical Screening History

Ever had a pap?	☐ Yes – Exam Date: _________ ☐ No ☐ Unknown
History of abnormal paps?	☐ Yes ☐ No ☐ Unknown
Ever had a hysterectomy?	☐ Yes – Procedure Date: _________ ☐ No ☐ Unknown Reason for hysterectomy: _______________ ___________________________________
Do you have a cervix?	☐ Yes ☐ No ☐ Unknown
Ever had a mammogram?	☐ Yes – Exam Date: _________ ☐ No ☐ Unknown
Ever had a breast biopsy?	☐ Yes – Biopsy Date: _________ ☐ No ☐ Unknown
Ever had a Clinical Breast Exam (CBE)?	☐ Yes – Exam Date: _________ ☐ No ☐ Unknown
How often do you perform a Self-Breast Exam (SBE)?	☐ Monthly ☐ Never ☐ Once a Year ☐ Several times a Year ☐ Weekly ☐ Unknown
Are you still having menstrual periods?	☐ Yes – Date of last menstrual period: _________ ☐ No Age at first period: _____ Age at last period: _____
Have you had any abnormal/irregular bleeding (including spotting)?	☐ Yes ☐ No ☐ Unknown

Family History of Cancer

Have any of your relatives been diagnosed with breast, cervical, ovarian, and/or colorectal cancer?
☐ Yes (Complete information below) ☐ No ☐ Unknown

Relative: _____________ **Age of diagnoses**: _______ **Cancer Type**: ☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

Relative: _____________ **Age of diagnoses**: _______ **Cancer Type**: ☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

Relative: _____________ **Age of diagnoses**: _______ **Cancer Type**: ☐ Breast ☐ Cervical ☐ Ovarian ☐ Colorectal

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MEDICAL HISTORY	
Breast History	
Have you ever had breast reduction surgery?	☐ Yes ☐ No
Have you ever had any other breast surgery?	☐ Yes ☐ No
Do you have breast implants?	☐ Yes ☐ No
Have you ever been told by a health care provider that you have breast disease?	☐ Yes ☐ No
Sexual History	
In the last 24 hours, have you douched or used anything in your vagina?	☐ Yes ☐ No
Are you currently sexually active?	☐ Yes ☐ No
Have you ever had a sexually transmitted disease?	☐ Yes ☐ No
Do you use birth control?	☐ Yes ☐ No If yes, what? _______________
Do you have any pain or bleeding with intercourse?	☐ Yes ☐ No
Do you have any sexual concerns that you would like to discuss?	☐ Yes ☐ No
Do you have a history of domestic violence or sexual abuse?	☐ Yes ☐ No
Pregnancy History	
How old were you when you completed your first full-term pregnancy?	Age: ________________
Did you breast feed any of your children?	☐ Yes ☐ No If yes, how long? ______ months
How many times have you been pregnant?	Number of pregnancies: ___________
How many living children do you have?	Number of living children: __________
How many miscarriages (or abortions) have you had?	Miscarriages/abortions: ____________
How many tubal (ectopic) pregnancies have you had?	Tubal pregnancies: _____________
Any complications with pregnancy?	☐ Yes ☐ No Describe complications: _____ ____
Other Medical History	
Are you having any symptoms of menopause or "the change"?	☐ Yes ☐ No If yes, explain: _______________ ____
Do you have any unusual vaginal discomfort (include discharge, dryness, itching, odor, bleeding, etc.)?	☐ Yes ☐ No
Do you have a history of endometriosis/fibroids?	☐ Yes ☐ No
Do you tend to lose urine when you cough or sneeze? Other times?	☐ Yes ☐ No Other: ____________________
Do you have any problem moving your bowels?	☐ Yes ☐ No
Do you have any of these conditions?	☐ Rectal Bleeding ☐ Constipation ☐ Diarrhea ☐ Lupus ☐ Hypertension ☐ Diabetes ☐ Hepatitis ☐ None ☐ Other: _________________________
Do you have any conditions that cause your immune system to be weakened in any way?	☐ Yes ☐ No If yes, explain: ______________ ____
Do you have any condition/situation which will make the exam difficult for you today?	☐ Yes ☐ No If yes, explain: ______________ ____

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Please list all medications you are taking:		
Type and Dose	**Reason**	**How long have you taken this?**

Preferred pharmacy: ________________________________

Please list all hospitalizations and surgeries you have had:		
Type	**Reason**	**Complications?**

Please list any allergies:

____

____

____

____

Thank you for taking the time to complete this lengthy history. We hope it will better help us to serve you!