Utah Department of Health & Human Services

# UCCP Patient Enrollment

**DEMOGRAPHICS:**

**FIRST NAME:** **LAST NAME:**

**MIDDLE INITIAL:** **MAIDEN NAME IF APPLICABLE:**

**D.O.B:**

**ADDRESS:**

- **Street/P.O BOX:**
- **CITY:**
- **COUNTY:**
- **STATE:**
- **ZIP:**

**CONTACT INFROMATION:**

- **☐HOME:**
- **☐WORK:**
- **☐MOBILE:**

**EMERGENCY CONTACT:**

- **NAME:**
- **NUMBER:**

**PRIMARY HEALTH CARE PROVIDER:**

**RACE AND ETHNICITY:**

- **☐ WHITE**
- **☐ BLACK OR AFRICIAN AMERICAN**
- **☐ ASIAN**
- **☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**
- **☐ AMERICAN INDIAN OR ALASKAN NATIVE**
- **☐ UNKNOWN**
- **☐ HISPANIC**

**PRIMARY LANGUAGE:**

- **☐ ENLGISH**
- **☐ SPANISH**
- **☐ OTHER:**

**HEALTH INSURANCE:**

- **☐ NONE**
- **☐ MEDICARE**
  - **SUBSCRIBER/MEMBER #:**
  - **HEALTH INSRUANCE COMPANY NAME:**
- **☐ PRIVATE INSURANCE**
- **☐ MEDICAID**

- **GROUP #:**

**TOTAL HOUSEHOLD FAMILY INCOME (OF ALL WORKING ADULTS OVER AGE OF 19) PER YEAR?:**

**NUMBER OF FAMILY MEMBERS SUPPORTED BY THIS INCOMING (SPOUSE, CHILDREN UNDER 19 YEARS OF AGE AND SELF INCLUDED)?:**

**ARE YOU PREGNANT OR BREAST FEEDING?**

- ☐ **YES**
- ☐ **NO**

**HOW DID YOU HEAR ABOUT THIS PROGRAM?:**

- ☐

**HIGHEST LEVEL OF EDUCATION COMPLETED:**

- ☐ **LESS THAN HIGH SCHOOL**
- ☐ **SOME HIGH SCHOOL**
- ☐ **HIGH SCHOOL GRADUATE OR EQUIVALENT**
- ☐ **SOME COLLEGE OR HIGHER**
- ☐ **DON'T KNOW/ NOT SURE**
- ☐ **DON'T WANT TO ANSWER**

**BREAST QUESTIONS:**

- **Have you ever had a mammogram?**
  - ☐ **YES, WHEN AND WHERE WAS YOUR LAST MAMMOGRAM?**
    - **MONTH:**
    - **YEAR:**
    - **FACILITY:**
  - ☐ **NO**
- **Do you have breast implants?**
  - ☐ **YES**
  - ☐ **NO**
- **Have you ever had breast cancer?**
  - ☐ **YES,** WHEN? MONTH: YEAR:
  - ☐ **NO**
- **Did breast symptoms lead to this visit?**
  - ☐ **YES :**
  - ☐ **NO**
- **Family History of breast cancer?**

    - ☐ **YES**
    - ☐ **NO**
- **Family history of Ovarian Cancer?**
    - ☐ **YES**
    - ☐ **NO**
- **Do you have Ashkenazi Jewish Heritage?**
    - ☐ **YES**
    - ☐ **NO**
- **Have you received radiation therapy to the chest prior to age 30 usually for Hodgkin's Lymphoma?**
    - ☐ **YES**
    - ☐ **NO**
- **Have you been diagnosed with BRCA1 or BRCA2?**
    - ☐ **YES**
    - ☐ **NO**

**Tobacco Questions:**

- **Do you smoke?**
    - ☐ **YES**
    - ☐ **NO**
- **Are you interested in quitting?**
    - ☐ **YES**
    - ☐ **NO**
- **About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?:**
    - ☐ **# OF HOURS**
    - ☐ **LESS THAN ONE**
    - ☐ **NONE**
    - ☐ **DON'T WANT TO ANSWER**

**CERIVCAL QUESTIONS:**

- **Have you ever had a Pap smear?**
    - ☐ **YES, WHEN?**
        - **MONTH:**
        - **YEAR:**
    - ☐ **NO**
- **Have you ever had an abnormal Pap smear?**
    - ☐ **YES**
    - ☐ **NO**

- **Did pelvic/cervical symptoms lead to this visit?**
  - **☐ YES :**
  - **☐ NO**
- **Have you had a hysterectomy?**
  - **☐ YES, WHEN?**
    - **MONTH:**
    - **YEAR:**
  - **☐ NO**
- **When was your last menstrual period?**
  - **Date:**
- **Do you have a history of cervical, vaginal or vulvar cancer?**
  - **☐ YES**
  - **☐ NO**
- **Have you had recurrent or persistent HPV?**
  - **☐ YES**
  - **☐ NO**
- **Do you take daily oral steroids for greater than 2 years, methotrexate or other medications that can weaken your immune system?**
  - **☐ YES**
  - **☐ NO**
- **Do you have HIV/AIDS?**
  - **☐ YES**
  - **☐ NO**
- **Are you and organ transplant recipient?**
  - **☐ YES**
  - **☐ NO**