Client Identification

Program # ___ ___ ___

ID # ___ ___ ___ ___ ___ ___ ___ ___ ___

Enrollment Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

Last Name _____

First Name _____ Middle Initial _____

Address _____

City _____

State ___ ___ Zip ___ ___ ___ ___ ___ County of Residence ___ ___ ___ *(001-099, or 111 for outside Iowa)*

Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Email _____

IOWA Health and Human Services Public Health

Complete this form once per year at annual enrollment. Please PRINT all information.

What is the primary language spoken in your home:

- ◯ 1. English
- ◯ 2. Spanish
- ◯ 3. Arabic
- ◯ 4. Chinese
- ◯ 5. French
- ◯ 6. Italian
- ◯ 7. Japanese
- ◯ 8. Korean
- ◯ 9. Polish
- ◯ 10. Russian
- ◯ 11. Tagalog
- ◯ 12. Vietnamese
- ◯ 13. Creole
- ◯ 14. Portuguese
- ◯ 15. Hmong
- ◯ 16. Other _____

Do you want to receive written health information in:

- ◯ 1. English
- ◯ 2. Spanish
- ◯ 3. Vietnamese
- ◯ 4. Other _____

Gender Identity ***(mark only one option)***:

- ◯ 1. Female
- ◯ 2. Trans Man
- ◯ 3. Trans Woman
- ◯ 4. Other _____
- ◯ 5. Don't Know
- ◯ 6. Refused

Sexual Orientation ***(mark only one option)***:

- ◯ 1. Straight or Heterosexual
- ◯ 2. Lesbian
- ◯ 3. Gay
- ◯ 4. Bisexual
- ◯ 5. Other _____
- ◯ 6. Don't Know
- ◯ 7. Refused

Client Demographic Information

1. First time **ever** enrolled in the Iowa Care for Yourself program?
   - ◯ 1. Yes
   - ◯ 2. No ***(continue with questions 2-5)*** →

   1a. Birth Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

   1b. Maiden Name ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

   1c. Hispanic or Latino Origin?

   ◯ 1. Yes ◯ 2. No ◯ 3. Unknown

   Please answer 1d-1i to identify your race

Yes	No	Unknown	
◯	◯	◯	1d. White
◯	◯	◯	1e. Black or African American
◯	◯	◯	1f. Asian
◯	◯	◯	1g. Native Hawaiian or Other Pacific Islander
◯	◯	◯	1h. American Indian or Alaska Native
◯	◯	◯	1i. Some other race

   (Continue with questions 2-5)

2. Health Insurance ***(mark only one option)***
   - ◯ 1. None
     - 1a. Date referred to insurance __ __ /__ __ /__ __ __ __ *(mm/dd/yyyy)*
   - ◯ 2. Insurance *(Includes Medicare Part B)*
   - ◯ 3. Medicare A *(not Part B)*
   - ◯ 4. Under-insured *(Assistance with co-pay and/or high deductible)*
3. Monthly Income $___, ___ ___ ___
4. Family Unit Size ___ ___
5. Education ***(check highest level attained)***
   - ◯ 1. Less than 9th grade
   - ◯ 2. Some high school
   - ◯ 3. High school graduate or equivalent
   - ◯ 4. Some college or higher
   - ◯ 5. Don't know/Not sure

Client Identification

Program # __ __ __ Last name _____ Enrollment Date __ __ / __ __ / __ __ __

ID # __ __ __ __ __ __ __ __ __ First Name_____ Middle Initial _____

Client Medical History

6. Have you had breast cancer?
   ◯ 1. Yes ◯ 2. No ◯ 3. Don't know/Not sure

7. Has your mother, grandmother, aunt, sister, or daughter had breast cancer?
   ◯ 1. Yes ◯ 2. No ◯ 3. Don't know/Not sure

8. Have you had a hysterectomy?
   ◯ 1. Yes → 8a. Due to cervical cancer? → ◯ 1. Yes ◯ 2. No ◯ 3. Don't know/Not sure
   ◯ 2. No
   ◯ 3. Don't know/Not sure
   8b. Cervix present? → ◯ 1. Yes ◯ 2. No ◯ 3. Don't know/Not sure

Client Smoking History

9. Do you now smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
   ◯ 1. Current Smoker
   ◯ 2. Quit (1-12 months ago)
   ◯ 3. Quit (More than 12 months ago)
   ◯ 4. Never Smoked

10. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?

__ __ Hours
◯ Less than one
◯ None

To be completed by Program Coord.: (for 1-3, check all that apply)

11. Client:
   1. Fax referral to a proactive Quitline (***check only one of a or b***):
      ◯ a. Signed by participant
      ◯ b. Verbal confirmation provided
   ◯ 2. Referred to a local community-based cessation program
   ◯ 3. Provided Quitline contact information
   ◯ 4. Not referred to Quitline or community cessation program or provided Quitline contact information
   ◯ 5. Refused any referral or information