

PERSONAL HISTORY FORM

For Clinic Staff use only

Chart #:

Enrollment Date: _____

I have verified this patient's Lawful Presence documentation.

Instructions: Please fill in each part below. **Shaded boxes need to be filled in completely.**

IDENTIFICATION	Name: Last: _____	First: _____	Middle: _____	Maiden: _____											
	Last 4 numbers of your Social Security Number: _____	Date of Birth: ____/____/____		Age: ____											
	<p>Do you consider yourself Latina, Hispanic, or Spanish? Choose one below.</p> <p><input type="checkbox"/> YES, I am Latina and/or Hispanic. Fill out box on right. Check all that are true.</p> <p><input type="checkbox"/> NO, I am not Latina or Hispanic. Fill out box on right.</p> <p><input type="checkbox"/> I am NOT SURE if I am Latina or Hispanic. Fill out box on right.</p> <p><input type="checkbox"/> I DO NOT WANT TO ANSWER. Fill out box on right.</p>														
	<p>What race(s) are you? Check all that are true:</p> <table border="0"> <tr> <td><input type="checkbox"/> Latina-White</td> <td><input type="checkbox"/> Latina-Alaska Native</td> <td><input type="checkbox"/> I am not sure</td> </tr> <tr> <td><input type="checkbox"/> Latina-Black/African American</td> <td><input type="checkbox"/> Latina-Aleutian Islander</td> <td><input type="checkbox"/> I do not want to answer</td> </tr> <tr> <td><input type="checkbox"/> Latina-Asian</td> <td><input type="checkbox"/> Latina-Native Hawaiian</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Latina-American Indian</td> <td><input type="checkbox"/> Latina-Pacific Islander</td> <td></td> </tr> </table>				<input type="checkbox"/> Latina-White	<input type="checkbox"/> Latina-Alaska Native	<input type="checkbox"/> I am not sure	<input type="checkbox"/> Latina-Black/African American	<input type="checkbox"/> Latina-Aleutian Islander	<input type="checkbox"/> I do not want to answer	<input type="checkbox"/> Latina-Asian	<input type="checkbox"/> Latina-Native Hawaiian		<input type="checkbox"/> Latina-American Indian	<input type="checkbox"/> Latina-Pacific Islander
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ENROLLMENT	<p>Do you have private insurance or Medicaid?</p> <p><input type="checkbox"/> Yes, I have private insurance. Check below if any are true.</p> <p style="padding-left: 20px;"><input type="checkbox"/> but I have a high deductible</p> <p style="padding-left: 20px;"><input type="checkbox"/> but it does not cover cancer screening</p> <p><input type="checkbox"/> Yes, I have Medicaid</p> <p><input type="checkbox"/> No, I do not have private insurance</p>	<p>Do you have Medicare?</p> <p><input type="checkbox"/> Yes, part A only</p> <p><input type="checkbox"/> Yes, parts A and B</p> <p><input type="checkbox"/> No, I do not have Medicare</p>	<p>Please send a reminder letter:</p> <p><input type="checkbox"/> In English</p> <p><input type="checkbox"/> In Spanish</p> <p><input type="checkbox"/> Do not send reminder letter</p>								
	<p>To the best of my knowledge, the GROSS MONTHLY income for my household is: \$ _____</p>	<p>Number of people living on this income including myself (this may include people not living in your house): _____</p>									
	<p>How did you hear about these free breast and cervical cancer screening exams from WWC? Check all that are true.</p> <table border="0"> <tr> <td><input type="checkbox"/> 9Health Fair</td> <td><input type="checkbox"/> Newspaper Ad</td> <td><input type="checkbox"/> Women's Wellness Connection event or staff person</td> </tr> <tr> <td><input type="checkbox"/> Brochure / Poster</td> <td><input type="checkbox"/> Radio Ad</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Friend / Family Member</td> <td><input type="checkbox"/> TV Ad</td> <td></td> </tr> </table>			<input type="checkbox"/> 9Health Fair	<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Women's Wellness Connection event or staff person	<input type="checkbox"/> Brochure / Poster	<input type="checkbox"/> Radio Ad	<input type="checkbox"/> Other _____	<input type="checkbox"/> Friend / Family Member	<input type="checkbox"/> TV Ad
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CONTACT	Work Phone number: (____) ____ - _____	Mailing Address: Street: _____		
	Home Phone number: (____) ____ - _____	City: _____	State: _____	Zip: _____
	Cell Phone number: (____) ____ - _____	Email Address: _____		
	Phone number for the future: List a # for someone who could call you if your phone # changes in the future or in an emergency: (____) ____ - _____			County: _____