Healthy Lifestyle Questionnaire

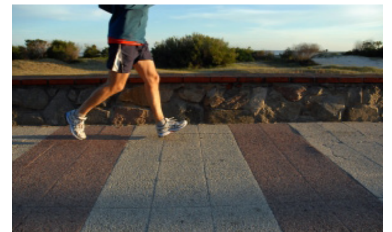
Please fill out this form. Filling out this form will help Every Woman Matters (EWM) and the Nebraska Colon Cancer Screening Program (NCP) determine what services are best for you.

Even if you are not able to get services, you can still get health education.

WHAT YOU NEED TO KNOW:

- Please answer ALL questions. If you don't we will call you or send the form back to you and this could delay important health screenings.
- Please PRINT clearly. Use a black or blue ink pen. Do not use pencil.
- This is NOT your screening card. Please do not make an appointment with your health care provider until you get a Screening Card.

Thank you for taking time for your health!



Version: February 2016

Informed Consent and Release of Medical Information

- **You must read pages 2 and 3 to be a part of the Every Woman Matters Program and/or the Nebraska Colon Cancer Screening Program.**
- **You are NOT able to enroll until all pages are filled out.**

EVERY WOMAN MATTERS (WOMEN)

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
  - I must be between 40 and 74 years of age to receive services
  - I cannot be over income guidelines
  - If I have insurance, EWM will only pay after my insurance pays
  - I must be a female (per Federal Guidelines)
  - I will notify EWM if I do not wish to be a part of this program anymore

- I know that if I am 40-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and Program Guidelines. I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.

- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.

- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM.

NEBRASKA COLON CANCER SCREENING PROGRAM (MEN and WOMEN)

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I know:
  - I must be between 50 and 74 years of age to receive services (there are no exceptions)
  - I cannot be over income guidelines
  - If I have insurance, NCP will only pay after my insurance pays
  - I must re-enroll in NCP every year
  - I must have a primary care doctor listed
  - I will notify NCP if I do not wish to be a part of this program anymore
  - I must be a Nebraska resident

- If I am eligible to participate, I understand that NCP will look at my health history and tell me what colon cancer screening test I am eligible for.

- Based upon my health history and what type of test I am eligible for, I know that NCP may provide me with a Fecal Occult Blood Test (FOBT) kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive an FOBT from the program and have a positive test, it will be followed up with a colonoscopy.
  - If I receive a colonoscopy through NCP I understand that I may be asked to pay 10% of the cost.
  - I understand that my payments will help others with colonoscopy costs through NCP.

- I will talk with my health care provider about the screening test(s) for colon cancer and understand possible side effects or discomforts.

- I will talk with my health care provider about how I am going to pay for any tests or services that are not paid by NCP.

- I understand that NCP does not pay for treatment if I am diagnosed with colon cancer. NCP staff will assist me in finding treatment resources.

 Continue Reading on Page 3 ~ You MUST Sign and Date Page 3 ---→

Informed Consent and Release of Medical Information

I know that:

- I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM/NCP may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.

- Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM/NCP, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.

- My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and cervical cancer screening, heart disease and diabetes screening, follow up exams, colorectal screening, diagnostic tests and/or treatment to EWM/NCP.

- To assist me in making the best health care decisions, EWM/NCP may share clinical and other health care information including lab results and health history with my health care providers.

- My name, address, email, social security number and/or other personal information will be used only by EWM/NCP. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.

- Other information may be used for studies approved by EWM/NCP and/or The Centers for Disease Prevention and Control (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

In order to be eligible for EWM/NCP you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. Please check which box applies to you.

- For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

❍ I am a citizen of the United States.

OR

❍ I am a qualified alien under the federal Immigration and Nationality Act. I am attaching a front and back copy of my USCIS documentation. **(example: permanent resident card)**

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Please Print Your Name (first, middle, last) _______________ Your Signature _______________

month / day / year — Date of Your Signature

month / day / year — Your Date of Birth

Be Sure to Print Your Name, Sign and Date This Page ⇢

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: Please answer each question and PRINT clearly!

Version: February 2016

DEMOGRAPHICS

First Name: ___________________________ Middle Initial: ______ Last Name: __________________________________

Maiden Name: ________________________ Marital Status: ❍Single ❍Married ❍Divorced

Birthdate: month / day / year Gender: ❍Female ❍Male Social Security #: _______-_______-_______

Address: ____ Apt. # __________________

City: ____________________________________ County: _______________________ State: _______ Zip: ___________

Preferred way of contact?: ❍Home ❍Work ❍Cell
Home Phone: (______)______________ Work Phone: (______)______________ Cell Phone: (______)______________

Yes I want to receive program information by email. Email: ____

In case we can't reach you:
Contact person: ____ Relationship: ❍Spouse ❍Family/Friend ❍Other__________________________

Phone: (_________)__________________________________ ❍Home ❍Work ❍Cell

Address: ____ City: ______________________ State:______ Zip:__________

Are you of **Hispanic/Latina(o)** origin? ❍Yes ❍No ❍Unknown Country of origin: _____________________________________

What is your **primary language** spoken in your home? ❍English ❍Spanish ❍Vietnamese ❍Other______________________

What **race or ethnicity** are you?
(check all boxes that apply)

- ❍American Indian/Alaska Native Tribe________________________
- ❍Black/African American
- ❍Mexican American
- ❍White
- ❍Asian
- ❍Pacific Islander/Native Hawaiian
- ❍Other____
- ❍Unknown

Are you a **Refugee**? ❍Yes ❍No ❍DK* If yes, where from: ____

Highest level of **education** completed: ❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10 ❍11 ❍12 ❍13 ❍14 ❍15 ❍16 ❍16+ ❍GED ❍Don't Know ❍Don't Want to Answer

How did you **hear about the program**: ❍Doctor/Clinic ❍Family/Friend ❍Agency ❍Newspaper/Radio/TV ❍I am a Current/Previous Client ❍Community Health Worker ❍Other _______________________________________

INCOME & INSURANCE

I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.

What is your **household income** before taxes? ❍Weekly ❍Monthly ❍Yearly Income: $ _______________________
Please Note: Self employed are to use net income after taxes.

How many **people** live on this income? ❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10 ❍11 ❍12

Do you have **insurance**? ❍Yes ❍None/No Coverage If **yes**, is it:

- ❍Medicare (for people 65 and over)
  - ❍Part A and B
  - ❍Part A only
- ❍Medicaid (full coverage for self)
- ❍Private Insurance with or without Medicaid Supplement
  (please list)__________________________________

 You're On a Roll.....Continue to Page 5

BREAST & CERVICAL

****ONLY women need to answer the questions in this box**

1. Have **you** ever had any of the **following tests**?:

Pap test ❍Yes ❍No ❍DK* Most Recent Date____/____/____ The result: ❍Normal ❍Abnormal ❍DK*

Mammogram *(breast x-ray)* ❍Yes ❍No ❍DK* Most Recent Date____/____/____ The result: ❍Normal ❍Abnormal ❍DK*

2. Have **you** ever had a **hysterectomy** *(removal of the uterus)*? ❍No ❍Yes ❍DK*

 2a. Was your **hysterectomy** to treat cervical cancer? ❍No ❍Yes ❍DK*

3. Has your ***mother, sister or daughter*** ever had **breast cancer**? ❍No ❍Yes ❍DK*

4. Have **you** ever had **breast cancer**? ❍No ❍Yes ❍DK* When: _____/_____/_____

5. Have **you** ever had **cervical cancer**? ❍No ❍Yes ❍DK* When: _____/_____/_____

**DK - Don't Know/Not Sure*

COLON CANCER

1. How many **1st degree relatives,** excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have **colon cancer or rectal cancer**? ❍0 ❍1 ❍2 ❍3+ ❍DK*

2. How many of those family members with **colon cancer** were **under the age of 60**? ❍0 ❍1 ❍2 ❍3+ ❍DK*

3. How many **1st degree relatives,** excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have **polyps in the colon**? ❍0 ❍1 ❍2 ❍3+ ❍DK*

4. How many of those family members with **polyps** were **under the age of 50**? ❍0 ❍1 ❍2 ❍3+ ❍DK*

5. How many **1st degree relatives,** excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have **other types of cancer**? ❍0 ❍1 ❍2 ❍3+ ❍DK*

 5a. What kind of **cancer** did they have?____

6. Have **you** ever been told that you have had **polyps** in the colon? ❍Yes ❍No ❍DK*

 6a. What **type of polyps** did you have? ______________________ **How many** polyps did you have?____________________

7. Have **you** ever had any of the **following tests**? *(Dates and results need to be marked)*:

Fecal Occult Blood Test ❍Yes ❍No ❍DK* Most Recent Date____/____/____ The result: ❍Normal ❍Abnormal

Sigmoidoscopy ❍Yes ❍No ❍DK* Most Recent Date____/____/____ The result: ❍Normal ❍Abnormal
Were polyps removed? ❍Yes ❍No ❍DK*

Colonoscopy ❍Yes ❍No ❍DK* Most Recent Date____/____/____ The result: ❍Normal ❍Abnormal
Were polyps removed? ❍Yes ❍No ❍DK*

Double Contrast Barium Enema (DCBE) ❍Yes ❍No ❍DK* Most Recent Date____/____/____ The result: ❍Normal ❍Abnormal

8. Have **you** ever been told by a doctor, nurse, or other health professional that you have had:

Condition			
Crohns Disease	❍Yes	❍No	❍DK*
Familial Adenomatous Polyposis (FAP)	❍Yes	❍No	❍DK*
Hereditary Non Polyposis Colorectal Cancer (HNPCC)	❍Yes	❍No	❍DK*
Inflammatory Bowel Disease (IBD)	❍Yes	❍No	❍DK*
Ulcerative Colitis	❍Yes	❍No	❍DK*

9. Are **you** currently under a doctor's care for any of the above conditions? ❍Yes ❍No ❍DK*

10. Within the last **30 days** have you had bleeding from the rectum? ❍Yes ❍No ❍DK*

 10a. What did your doctor say about your **rectal bleeding**? ________________________________

11. Have **you** ever been told that you have had **colon or rectal cancer**? ❍Yes ❍No ❍DK*

 11a. If yes, **when** were you diagnosed? ______/______/______

12. My **Every Woman Matters or Primary doctor** is: (please print) ________________________________

Name of Clinic________________________________ City___________________ Phone__________________

**DK - Don't Know/Not Sure*

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: Please answer each question and PRINT clearly!

Version: February 2016

DIET & PHYSICAL ACTIVITY

1. How much **fruit** do you eat in an average day? *(1 cup equals 1 large banana or 1 medium apple)* ________ Cups ❍DK* ❍DW*
2. How many **vegetables** do you eat in an average day? *(1 cup equals 12 baby carrots or 1 ear corn)* ________ Cups ❍DK* ❍DW*
3. Do you eat 2 servings or more of **fish** weekly? *(1 serving equals 7 ounce can tuna or 1 filet pollock)* ❍Yes ❍No ❍DK* ❍DW*
4. Do you eat 3 ounces or more of **whole grains** daily? ❍Yes ❍No ❍DK* ❍DW*
   (1 ounce equals 1 serving, a serving equals 1 slice whole wheat bread, 3 cups popped popcorn)
5. Do you drink less than 36 ounces of **beverages with added sugars** weekly? ❍Yes ❍No ❍DK* ❍DW*
   (3 (12 ounce) cans regular soda, juice, alcohol, specialty drinks)
6. Are you currently watching or reducing your **sodium** or **salt** intake? ❍Yes ❍No ❍DK* ❍DW*
7. How much **moderate physical activity** do you get in a week? _______ Minutes ❍DK* ❍DW*
   (walking, water aerobics, general gardening, able to talk/hold conversation)
8. How much **vigorous physical activity** do you get in a week? _______ Minutes ❍DK* ❍DW*
   (running, race-walking, aerobic dancing, bicycling, not able to talk/hold conversation)

**DK - Don't Know/Not Sure *DW - Don't Want to Answer*

CHOLESTEROL

1. Do you have **high cholesterol**? ❍Yes ❍No ❍DK* ❍DW*

   If no, skip to the next set of questions below (BLOOD PRESSURE)
2. Did your doctor **prescribe medication** to help lower your **cholesterol**? ❍Yes ❍No ❍DK* ❍DW*

   If no, skip to the next set of questions below (BLOOD PRESSURE)
3. During the **past 7 days**, how many days (including today) did you take your medication as prescribed? ________ Days
4. On days you **did not take your medication** as prescribed, please tell us why.
   ❍Cost ❍Forgot to take
   ❍Side Effects ❍Need Refill
   ❍Don't Want to Take Meds
   ❍Other____________________

**DK - Don't Know/Not Sure *DW - Don't Want to Answer*

BLOOD PRESSURE

1. Do you have **high blood pressure**? ❍Yes ❍No ❍DK* ❍DW*

   If no, skip to the next set of questions below (DIABETES)
2. Did your doctor **prescribe medication** to help lower your **blood pressure**? ❍Yes ❍No ❍DK* ❍DW*

   If no, skip to the next set of questions below (DIABETES)
3. During the **past 7 days**, how many days (including today) did you take your medication as prescribed? ________Days
4. On days you **did not take your medication** as prescribed, please tell us why.
   ❍Cost ❍Forgot to take
   ❍Side Effects ❍Need Refill
   ❍Don't Want to Take Meds
   ❍Other____________________
5. Do you measure your **blood pressure** at home or using another calibrated source (like a pharmacy)? ❍Yes ❍No ❍DK* ❍DW*

   5a. If no, provide reason: ❍No, Never told to measure ❍No, Don't know how to measure ❍No, Don't have equipment to measure

   5b. How often do you measure your **blood pressure** at home or using other calibrated sources (like a pharmacy)? ❍Multiple times per day ❍A few times per week ❍Daily ❍Monthly ❍Weekly ❍DK* ❍DW*

   5c. Do you regularly share your blood pressure readings with a health care provider for feedback? ❍Yes ❍No ❍DK* ❍DW*

**DK - Don't Know/Not Sure *DW - Don't Want to Answer*

DIABETES

1. Do you have **Diabetes**? (Either Type 1 or Type 2) ❍Yes ❍No ❍DK* ❍DW*

   If no, skip to the next set of questions on Page 7 (HEART)
2. Did your doctor **prescribe medication** to help lower your **blood sugar (for diabetes)**? ❍Yes ❍No ❍DK* ❍DW*

   If no, skip to the next set of questions on Page 7 (HEART)
3. During the **past 7 days**, how many days (including today) did you take your medication as prescribed? ________Days
4. On days you **did not take your medication** as prescribed, please tell us why.
   ❍Cost ❍Forgot to take
   ❍Side Effects ❍Need Refill
   ❍Don't Want to Take Meds
   ❍Other____________________

**DK - Don't Know/Not Sure *DW - Don't Want to Answer*

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: Please answer each question and PRINT clearly!

Version: February 2016

HEART

1. Have you been **diagnosed** by a healthcare provider as having any of these conditions: ❍Yes ❍No ❍DK* ❍DW*
   - ■coronary heart disease/chest pain
   - ■congenital heart defects
   - ■heart failure
   - ■stroke/transient ischemic attack (TIA)
   - ■vascular disease
   - ■heart attacK

*DK - Don't Know/Not Sure *DW - Don't Want to Answer

SMOKING STATUS

1. Do you **smoke**? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
   ❍Current Smoker
   ❍Quit (1-12 months ago)
   ❍Quit (More than 12 months)
   ❍Never smoked
   ❍DW*

2. Do you currently use **chewing tobacco, snuff, or snus**?
   ❍Everyday ❍Some days
   ❍Not at all ❍DW*

3. 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 ❍DW*

*DK - Don't Know/Not Sure *DW - Don't Want to Answer

DAILY LIFE

1. Thinking about your **physical health**, which includes physical illness and injury, on how many days during the past **30 days** was your physical health **not good**? _______ Days ❍DK* ❍DW*

2. Thinking about your **mental health**, which includes stress, depression, and problems with emotions, on how many days during the past **30 days** was your mental health **not good**? _______ Days ❍DK* ❍DW*

3. During the past **30 days**, on about how many days did poor physical or mental health keep you from doing your **usual activities**, such as self-care, work, or recreation? _______ Days ❍DK* ❍DW*

4. Are you limited in any activities because of physical, mental or emotional problems? ❍Yes ❍No ❍DK* ❍DW*

5. Do **you now have** any health problems that requires you to use **special equipment**, such as a cane, a wheelchair, a special bed or a special telephone? ❍Yes ❍No ❍DK* ❍DW*

   5a. If yes, what **type of disability**?
   ❍Emotional ❍Intellectual
   ❍Physical ❍Sensory

*DK - Don't Know/Not Sure *DW - Don't Want to Answer

SAFETY & WELLNESS

1. If you are a **woman**, how many days in the past year have you had 4 or more alcoholic drinks in a day?
   ❍Never ❍NA*
   ________ Days ❍DK* ❍DW*

2. If you are a **man**, how many days in the past year have you had 5 or more alcoholic drinks in a day?
   ❍Never ❍NA*
   ________ Days ❍DK* ❍DW*

3. Do you **feel safe** in your current relationship? ❍No ❍Yes ❍NA* ❍DW*

4. Have you been hit, kicked, punched or otherwise hurt by someone **in the past year**? ❍No ❍Yes ❍NA* ❍DW*

5. Is there a partner from a previous relationship who is making you feel **unsafe now**? ❍No ❍Yes ❍NA* ❍DW*

6. How often do you use **seat belts** when you drive or ride in a car?
   ❍Always ❍Nearly Always
   ❍Sometimes ❍Seldom
   ❍Never ❍DW*

7. During the past 12 months, have you had a **flu shot or flu mist**? ❍No ❍Yes ❍DK* ❍DW*

   7a. If not, please share why? ____

8. Have you had a **pneumonia shot**? ❍No ❍Yes ❍DK* ❍DW*

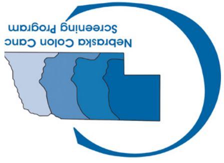
9. When did you last visit a **dentist or a dental clinic** for any reason?
   ❍Within past year
   ❍Within past 2 years
   ❍2 or more years ago
   ❍Never ❍DK* ❍DW*

10. When did you last have your **eyes checked** by a doctor or eye care provider?
   ❍Within past year
   ❍Within past 2 years
   ❍2 or more years ago
   ❍Never ❍DK* ❍DW*

*NA - Not Applicable *DK - Don't Know/Not Sure *DW - Don't Want to Answer

First Name: ____________ Last Name: ____________ Date of Birth: ____/____/____

Great Job! You Are Done! ⇢



Find out if you are eligible today!

Every Woman Matters & The Nebraska Colon Cancer Screening Programs offer important health screenings!

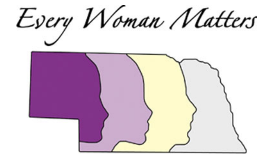
If you have questions, please contact the Nebraska Women's & Men's Health Programs:

Nebraska Women's & Men's Health Programs
301 Centennial Mall South ~ P.O. Box 94817
Lincoln, NE 68509-4817

Toll Free: 800-532-2227
In Lincoln: 402-471-0929
Fax: 402-471-0913

Websites: www.dhhs.ne.gov/womenshealth
www.dhhs.ne.gov/crc or www.StayIntheGameNE.com

Email: dhhs.ewm@nebraska.gov (Every Woman Matters)
dhhs.nccsp@nebraska.gov (Nebraska Colon Program)



Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation and the Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services. #5NU58DP003928-04/#5NU58DP004863-03

Version: February 2016

Find out what health screening services are best for you by filling out this form!

Make Time for Your Health. Do it for YOU & Your Family!