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:

You must **NOT** have health insurance that would pay for preventive services.

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!
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.

When I receive my Screening Card I will be given an opportunity to make a $5 donation to the program to help other women receive screening services.

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.
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.

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<tr>
<th>Please Print Your Name (first, middle, last)</th>
<th>Your Signature</th>
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| / / year                                   | / / year       |
| month day year                             | month day year |
| Your Date of Birth                         | Date of Your Signature |
### Client Information & Healthy Lifestyle Questionnaire

**INSTRUCTIONS:** Please answer each question and PRINT clearly!

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<th>First Name:</th>
<th>Middle Initial:</th>
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<th>Maiden Name:</th>
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**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: $ ____________________

**Forms will be returned if the income space is left blank.**

**DemoGraphics**

- **First Name:** ___
- **Middle Initial:** ___
- **Last Name:** ___
- **Maiden Name:** ___
- **Marital Status:** Single
- **Gender:** Female
- **Birthdate:** __________/________/__________
- **Birth Place:** City and State or Country of Birth
- **Social Security #: ___________ - ___________ - ___________**
- **Birth Place:** City and State or Country of Birth
- **Preferred way of contact:**
  - Home (_____) ______________________
  - Work (_____) ______________________
  - Cell (_____) ______________________

**INSTRUCTIONS:** Please answer each question and PRINT clearly!

- **Are you a Refugee?** Yes
- **Highest level of education completed:**
  - <9th grade
  - Some college or higher
  - Some high school
  - High school graduate or equivalent
  - Don’t Know
- **How did you hear about the program:**
  - Doctor/Clinic
  - Family/Friend
  - Agency
  - Community Health Worker
  - Other __________________________________

**Are you of Hispanic/Latina(o) origin?**

- Yes
- No
- Unknown

**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

- Refugee: Yes
- No
- DK*
- If yes, where from: __________________________

**What is your primary language spoken in your home?**

- English
- Spanish
- Vietnamese
- Other __________________________

**Income & Insurance**

- **Do you have insurance?** Yes
- **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) __________________________

**Forms will be returned if the income space is left blank.**

**How many people live on this income?**

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12

**How old are you?**

**Are you of Hispanic/Latina(o) origin?**

- Yes
- No
- Unknown

**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:**

- <9th grade
- Some college or higher
- Some high school
- High school graduate or equivalent
- Don’t Know

**How did you hear about the program:**

- Doctor/Clinic
- Family/Friend
- Agency
- Community Health Worker
- Other __________________________________

**INSTRUCTIONS:** Please answer each question and PRINT clearly!
**ONLY women need to answer the questions in this box**

### BREAST & CERVICAL

1. Have you ever had any of the following tests?:
   - Pap test
     - Yes / No / DK*
     - Most Recent Date ___/___/___
     - Result: Normal / Abnormal / DK*
   - Mammogram
     - Yes / No / DK*
     - Most Recent Date ___/___/___
     - Result: Normal / Abnormal / DK*

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

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

4. Have you ever had breast cancer?
   - Yes / No / DK*

5. Have you ever had cervical cancer?
   - Yes / No / DK*

### 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. Has your mother, sister or daughter ever had breast cancer?
   - Yes / No / DK*

4. Have you ever had breast cancer?
   - Yes / No / DK*

5. When: ___/___/___

6. What kind of cancer did they have?

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 ___/___/___
     - Result: Normal / Abnormal
   - Sigmoidoscopy
     - Yes / No / DK*
     - Most Recent Date ___/___/___
     - Result: Normal / Abnormal
   - Were polyps removed?
     - Yes / No / DK*
   - Colonoscopy
     - Yes / No / DK*
     - Most Recent Date ___/___/___
     - Result: Normal / Abnormal
   - Were polyps removed?
     - Yes / No / DK*
   - Double Contrast Barium Enema (DCBE)
     - Yes / No / DK*
     - Most Recent Date ___/___/___
     - Result: Normal / Abnormal

8. Have you ever been told by a doctor, nurse, or other health professional that you have had:
   - Crohn's Disease
   - Familial Adenomatous Polyposis (FAP)
   - Hereditary Non Polyposis Colorectal Cancer (HNPCC)
   - Inflammatory Bowel Disease (IBD)
   - Ulcerative Colitis

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
**INSTRUCTIONS:** Please answer each question and PRINT clearly!

| 1. How much fruit do you eat in an average day? (1 cup equals 1 large banana or 1 medium apple) | ____ Cups  DK* |
| 2. How many vegetables do you eat in an average day? (1 cup equals 12 baby carrots or 1 ear corn) | ____ Cups  DK* |
| 3. Do you eat fish at least two times a week? | Yes  No  DK* |
| 4. How many servings of grain products do you eat in a day? (serving equals 1 slice whole wheat bread, 3 cups popped popcorn, 1/2 cup rice/pasta, 3/4 cup oatmeal) | 1  2  3  4  5  6+  DK* |
| 4a. Of these servings, how many are whole grain? | Less than half  About half  DK* |
| 5. Do you drink less than 36 ounces of beverages with added sugars weekly? (3 [12 ounce] cans regular soda, juice, alcohol, specialty drinks) | Yes  No  DK* |
| 6. Are you currently watching or reducing your sodium or salt intake? | Yes  No  DK* |
| 7. How many minutes of physical activity do you get in a WEEK? (walking/running, aerobic dancing, water aerobics, general gardening, bicycling) | ____ Minutes  DK* |

## DIET & PHYSICAL ACTIVITY

### HIGH BLOOD PRESSURE

| 1. Has your doctor, nurse or other health professional EVER told you that you have: | Yes  No  DK* |
| 2. Do you take any medication prescribed by your doctors NOW to lower: | Yes  No  DK* |
| 3. During the past 7 days, how many days (including today) did you take your medication as prescribed: | _____ Days  DK* |
| 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* |
| 5. Do you check your BLOOD PRESSURE when you are not at the doctor’s office (at home, at pharmacy, or at a store, etc.)? | Yes  No  DK* |
| 5a. If no, provide reason: | No, never told to check  No, don’t know how to check  No, don’t have equipment  DK* |
| 5b. If yes, how often do you check your BLOOD PRESSURE: | Multiple times a day  Daily  Weekly  A few times per week  Monthly  DK* |
| 5c. If yes, do you share your BLOOD PRESSURE numbers with your doctor that you take at home, the pharmacy or a store? | Yes  No  DK* |

### HIGH CHOLESTEROL

| 1. Has your doctor, nurse or other health professional EVER told you that you have: | Yes  No  DK* |
| 2. Do you take any medication prescribed by your doctors NOW to lower: | Yes  No  DK* |
| 3. During the past 7 days, how many days (including today) did you take your medication as prescribed: | _____ Days  DK* |
| 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* |

### DIABETES

| 1. Has your doctor, nurse or other health professional EVER told you that you have: | Yes  No  DK* |
| 2. Do you take any medication prescribed by your doctors NOW to lower: | Yes  No  DK* |
| 3. During the past 7 days, how many days (including today) did you take your medication as prescribed: | _____ Days  DK* |
| 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* |

## CHOLESTEROL, BLOOD PRESSURE & DIABETES

### HEART

1. Have you been diagnosed by a healthcare provider as having any of these conditions: (mark all that apply)
   - Coronary Heart Disease/Chest Pain: Yes  No  DK*
   - Congenital Heart Defects: Yes  No  DK*
   - Heart Failure: Yes  No  DK*
   - Stroke/Transient Ischemic Attack (TIA): Yes  No  DK*
   - Vascular Disease: Yes  No  DK*
   - Heart Attack: Yes  No  DK*

2. Are you taking aspirin daily to help prevent a heart attack or stroke? Yes  No  DK*

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First Name: ____________  Last Name: ____________  Date of Birth: ____/____/_____
**Client Information & Healthy Lifestyle Questionnaire**

**INSTRUCTIONS:** Please answer each question and PRINT clearly!

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### SMOKING

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

### SAFETY & WELLNESS

1. **How many days in the last week have you had a drink containing alcohol?**
   - Never
   - DK*

2. **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*
   - DK*

3. **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*
   - DK*

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

5. **Have you had a pneumonia shot?**
   - Within past year
   - Within past 2 years
   - 2 or more years ago
   - Never
   - DK*

6. **When did you last visit a dentist or a dental clinic for any reason?**
   - Never
   - DK*

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### 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*

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*

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*

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

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

6. **Over the past 2 weeks, how often have you been bothered by any of the following problems:**
   - Not at all
   - Several days
   - More than half
   - Nearly every day

6a. **Little interest or pleasure in doing things:**
   - Not at all
   - Several days
   - More than half
   - Nearly every day

6b. **Feeling down, depressed, or hopeless:**
   - Not at all
   - Several days
   - More than half
   - Nearly every day

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First Name:  
Last Name:  
Date of Birth:  

Great Job! You Are Done!  

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*NA - Not Applicable  *DK - Don’t Know/Not Sure
Find out if you are eligible today!

Important health screenings!

Colon Cancer Screening Programs offer

Every Woman Matters & The Nebraska

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.