## Client Identification

Program # [redacted]

ID # [redacted]

Enrollment Date [redacted] (mm/dd/yyyy)

Last Name [redacted]

First Name [redacted] Middle Initial [redacted]

Address [redacted]

City [redacted]

State [redacted] Zip Code [redacted] County of Residence [redacted] *(001 – 099, or 111 for outside Iowa)*

Phone [redacted] *(XXX) XXX-XXXX* Email [redacted]

*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 [redacted]

Do you want to receive written health information in:

1. English
2. Spanish
3. Vietnamese
4. Other [redacted]

Gender Identity *(mark only one option)*:

1. Female
2. Trans Man
3. Trans Woman
4. Other [redacted]
5. Don't Know
6. Refused

Sexual Orientation *(mark only one option)*:

1. Straight or Heterosexual
2. Lesbian
3. Gay
4. Bisexual
5. Other [redacted]
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 [redacted] *(mm/dd/yyyy)*

1b. Maiden Name [redacted]

1c. Hispanic or Latina 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 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)* [redacted]
   - ◯ 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 $ [redacted]
4. Family Unit Size [redacted]
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 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. Unknown
  - 8b. Cervix present? ◯ 1. Yes ◯ 2. No ◯ 3. Unknown
- ◯ 2. No
- ◯ 3. Don't know/Not sure

## Client Smoking History

9. Smoking History *(mark only one option)*:

- ◯ 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 [redacted]
- ◯ Less than one
- ◯ None

### *To be completed by Program Coordinator: (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