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
   8b. Cervix present? → ◯ 1. Yes ◯ 2. No ◯ 3. Don't know/Not sure
   ◯ 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