Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control
Cancer Prevention, Education, Screening, and Treatment Program

Montgomery County Cancer Crusade
Colorectal Cancer Screening Form

Patient Information

Last Name:	Suffix: (Jr., etc.)	First Name:	Middle:
Date of Birth: (mm/dd/yyyy) / /	Age:	SSN: (last 4 digits **only**)	

Residential Address	Street Address:	Apartment/Room/Unit #:
	City: County: State: Zipcode:	

Telephone: Home ( ) – Work ( ) – Cell ( ) –

Demographic Information

Gender:	☐ Female	☐ Male	☐ Unknown
Ethnicity (Hispanic or Latino):	☐ Yes	☐ No	☐ Unknown
Race: (check all that apply)	☐ American Indian/Alaskan Native	☐ Asian	☐ Black/African American
	☐ Hawaiian/Other Pacific Islander	☐ White/Caucasian	☐ Unknown
Education: (highest level)	☐ No high school	☐ Some high school	☐ High school graduate
	☐ Greater than high school	☐ Unknown	

Country of Birth:

Primary Language: ☐ English ☐ Spanish ☐ Other: ____________________

Previous Enrollment

Have you ever been screened or treated for colon, oral, skin, or prostate cancer by any Maryland public health program? ☐ No ☐ Unknown ☐ Yes, list county(s):

Have you ever been screened for breast or cervical cancer in the BCCP? ☐ Yes ☐ No

Health Care Provider and Insurance Information

Do you have a primary health care provider? ☐ Yes ☐ No/Unknown

If yes, identify provider (last name, first name) or practice:

Are you covered by health insurance? ☐ Yes ☐ No ☐ Unknown

Health History

Do you have a history of any kind of cancer? ☐ Yes, specify: ☐ No ☐ Unknown

Have you *ever* used tobacco in any form?
☐ Yes ☐ No ☐ Unknown

If yes, check all products used: ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Spit tobacco (snuff, chewing, etc.)

Have you smoked 100 or more cigarettes over your lifetime? ☐ Yes ☐ No (Stop) ☐ Unknown

If yes, at what age did you first smoke? Age: ☐ Unknown

If you quit smoking, at what age did you quit? Age: ☐ Unknown

Average number of packs of cigarettes you smoke(d) each day (20 cigarettes per pack):

Program Use Only

		Client Identification	
Sponsor:	____________		
Session ID:	____________	CDB ID (system generated):	____________
Enrollment Date: (mm/dd/yyyy)	/ /	Local ID (optional):	____________
Interview Date: (mm/dd/yyyy)	/ /	Date of Data Entry into **CDB** (mm/dd/yyyy):	/ /
		Initials:	