



# 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.

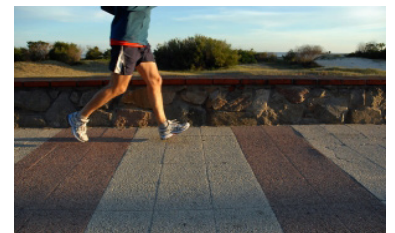
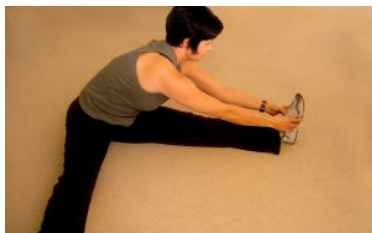
## WHAT YOU NEED TO KNOW:

- 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.
- After you send this to EWM/NCP, it will be reviewed to see what screenings you are eligible for. This usually takes up to 2 weeks.
- Once the program determines what screenings you are eligible for, a Screening Card and this HLQ, will be returned in the mail so that you can take them to your appointment to give to your healthcare provider.

## WHAT YOUR PROVIDER NEEDS TO KNOW:

- Screenings were determined based upon the HLQ submitted to EWM/NCP.
- This HLQ was mailed back to the client with a Screening Card. Client was instructed to bring the form so you can discuss benefits of healthy lifestyle behaviors.
- Clinics may keep the HLQ as a part of the client chart, if so desired.

Thank you for taking time for your health!



## ***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 (FEMALES)**

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
  - I must be between 35 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 35-74 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.

### **NEBRASKA COLON CANCER SCREENING PROGRAM (MALES and FEMALES)**

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I know:
  - I must be between 45 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 home based stool kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive a home based stool kit 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.

## 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 Control and Prevention (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. 4-111(1)(b), 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, 8 U.S.C. 1101 et seq., as such act existed on January 1, 2009, and is lawfully present in the United States. I am attaching a front and back copy of my USCIS documentation. **(for example, Permanent Resident Card or A-Number/Alien Registration Number)**

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

Your Date of Birth

month day year

Date of Your Signature

# Client Information & Healthy Lifestyle Questionnaire

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

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<b>DEMOGRAPHICS</b>	First Name:		Middle Initial:	Last Name:		
	Maiden Name:		Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed			
	Birthdate: ____/____/____ <small>month day year</small>		Gender: <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Transgender <input type="radio"/> Female to Male <input type="radio"/> Male to Female		Do you identify as: <input type="radio"/> Heterosexual <input type="radio"/> Lesbian <input type="radio"/> Bisexual <input type="radio"/> Gay	
	Social Security #: ____ - ____ - ____			Birth Place: <small>City and State or Country of Birth</small>		
	Address:					Apt. #:
	City:		County:		State:	Zip:
	Preferred way of contact:	<input type="radio"/> Home (____) _____ <input type="radio"/> Work (____) _____ <input type="radio"/> Cell (____) _____		Best time to reach you? <input type="radio"/> AM <input type="radio"/> PM <input type="radio"/> Yes, it is okay to text my cell phone.		
	<input type="radio"/> Yes, I want to receive program information by email. My email is: _____					
	In case we can't reach you:					
	Contact person:		Phone: (____) _____ <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell		Relationship: <input type="radio"/> Spouse <input type="radio"/> Family/Friend <input type="radio"/> Other _____	
Are you of Hispanic/Latina(o) origin?				<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
What is your primary language spoken in your home?				<input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Vietnamese <input type="radio"/> Other _____		
What race or ethnicity are you? <small>(check all boxes that apply)</small>		<input type="radio"/> American Indian/Alaska Native Tribe _____ <input type="radio"/> Black/African American <input type="radio"/> Mexican American <input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> Pacific Islander/Native Hawaiian <input type="radio"/> Other _____ <input type="radio"/> Unknown				
Are you a Refugee? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		If yes, where from:				
Highest level of education completed:		<input type="radio"/> <9th grade <input type="radio"/> Some high school <input type="radio"/> High school graduate or equivalent <input type="radio"/> Some college or higher <input type="radio"/> Don't Know				
How did you hear about the program:		<input type="radio"/> Doctor/Clinic <input type="radio"/> Family/Friend <input type="radio"/> Agency <input type="radio"/> Newspaper/Radio/TV <input type="radio"/> I am a Current/Previous Client <input type="radio"/> Community Health Worker <input type="radio"/> Other _____				

<b>INCOME &amp; INSURANCE</b>	<i>I may 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.</i>	
	What is your household income <b>before</b> taxes?	<input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly Income: \$ _____
	<b>Please Note:</b> - Self employed are to use net income after taxes. - If you do not have any income, please write \$0 in the income space.	
	How many <b>people</b> live on this income?	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12
Do you have <b>insurance</b> ?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , is it:	
<input type="radio"/> Medicare (for people 65 and over) <input type="radio"/> Part A and B <input type="radio"/> Part A only <input type="radio"/> Medicaid (full coverage for self) <input type="radio"/> Private Insurance with or without Medicaid Supplement (please list) _____		

# Client Information & Healthy Lifestyle Questionnaire

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

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<b>**ONLY females need to answer the questions in this box</b>				
<b>BREAST &amp; CERVICAL</b>	<b>1. Have you ever had any of the following tests?:</b>			
	<b>Pap test</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	Previous/Prior Pap Test Date: ___/___/___	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> DK*
	<b>HPV test</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	Previous/Prior HPV Test Date: ___/___/___	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> DK*
	<b>Mammogram</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	Previous/Prior Mammogram Date: ___/___/___	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> DK*
	2. Have <b>you</b> ever had a <b>hysterectomy</b> (removal of the uterus)?			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
	2a. Was your cervix removed?			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
2b. Was your <b>hysterectomy</b> to treat cervical cancer?			<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	
3. Has your <b>mother, sister or daughter</b> ever had <b>breast cancer</b> ?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
4. Have <b>you</b> ever had breast cancer?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	When: ___/___/___	
5. Have <b>you</b> ever had cervical cancer?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	When: ___/___/___	

<b>COLON CANCER</b>	1. How many <b>1st degree relatives, excluding yourself, (parents, brothers, sisters, children)</b> have been told they have <b>colon cancer or rectal cancer</b> ?		<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3+ <input type="radio"/> DK*	
	2. How many of those family members with <b>colon cancer</b> were <b>under the age of 60</b> ?		<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3+ <input type="radio"/> DK*	
	3. How many <b>1st degree relatives, excluding yourself, (parents, brothers, sisters, children)</b> have been told they have <b>polyps in the colon</b> ?		<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3+ <input type="radio"/> DK*	
	4. How many of those family members with <b>polyps</b> were <b>under the age of 50</b> ?		<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3+ <input type="radio"/> DK*	
	5. How many <b>1st degree relatives, excluding yourself, (parents, brothers, sisters, children)</b> have been told they have <b>other types of cancer</b> ?		<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3+ <input type="radio"/> DK*	
	5a. What kind of <b>cancer</b> did they have?			
	6. Have <b>you</b> ever been told that you have had <b>polyps</b> in the colon?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	
	6a. What <b>type of polyps</b> did you have? _____ <b>How many polyps</b> did you have? _____			
	7. Have <b>you</b> ever had any of the <b>following tests?</b> (Dates and results need to be marked):			
	<u>Home Based Stool Kit</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	Most Recent Date ___/___/___	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal
	<u>Sigmoidoscopy</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	Most Recent Date ___/___/___	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal
	Were polyps removed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
<u>Colonoscopy</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	Most Recent Date ___/___/___	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal	
Were polyps removed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*			
<u>Double Contrast Barium Enema (DCBE)</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	Most Recent Date ___/___/___	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal	
8. Have <b>you</b> ever been told by a doctor, nurse, or other health professional that you have had:				
Crohns Disease		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
Familial Adenomatous Polyposis (FAP)		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
Hereditary Non Polyposis Colorectal Cancer (HNPCC)		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
Inflammatory Bowel Disease (IBD)		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
Ulcerative Colitis		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
9. Are <b>you</b> currently under a doctor's care for any of the above conditions?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
10. Within the last <b>30 days</b> have you had bleeding from the rectum?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
10a. What did your doctor say about your <b>rectal bleeding</b> ?				
11. Have <b>you</b> ever been told that you have had <b>colon or rectal cancer</b> ?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
11a. If yes, <b>when</b> were you diagnosed?		___/___/___		
12. My <b>Every Woman Matters</b> or <b>Primary doctor</b> is: (please print)				
Name of Clinic	City	Phone		

\*DK - Don't Know/Not Sure

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Keep Moving for Your Health! →

# Client Information & Healthy Lifestyle Questionnaire

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

<b>DIET &amp; PHYSICAL ACTIVITY</b>	1. How much <b>fruit</b> do you eat in an average day? <i>(1 cup equals 1 large banana or 1 medium apple)</i>	_____ Cups	<input type="radio"/> DK*
	2. How many <b>vegetables</b> do you eat in an average day? <i>(1 cup equals 12 baby carrots or 1 ear corn)</i>	_____ Cups	<input type="radio"/> DK*
	3. Do you eat <b>fish</b> at least two times a week?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> DK*
	4. How many servings of <b>grain products</b> do you eat in a day? <i>(serving equals 1 slice whole wheat bread, 3 cups popped popcorn, 1/2 cup rice/pasta, 3/4 cup oatmeal)</i>	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6+ <input type="radio"/> DK*	
	4a. Of these servings, how many are <b>whole grain</b> ?	<input type="radio"/> Less than half <input type="radio"/> About half <input type="radio"/> More than half <input type="radio"/> DK*	
	5. Do you drink less than 36 ounces of <b>beverages with added sugars</b> weekly? <i>(3 (12 ounce) cans regular soda, juice, alcohol, specialty drinks)</i>	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> DK*
	6. Are you currently watching or reducing your <b>sodium</b> or <b>salt</b> intake?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> DK*
7. How many minutes of <b>physical activity</b> do you get in a <b>WEEK</b> ? <i>(walking/running, aerobic dancing, water aerobics, general gardening, bicycling)</i>	_____ Minutes	<input type="radio"/> DK*	

	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	DIABETES
1. Has your doctor, nurse or other health professional <b>EVER</b> told you that you have:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
2. Do you take any medication prescribed by your doctors <b>NOW</b> to lower:	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*
3. During the <b>past 7 days</b> , how many days <i>(including today)</i> did you take your medication as prescribed:	_____ Days <input type="radio"/> DK*	_____ Days <input type="radio"/> DK*	_____ Days <input type="radio"/> DK*
On days you <b>did not take your medication</b> as prescribed, please tell us why:	<input type="radio"/> Cost <input type="radio"/> Forgot to take <input type="radio"/> Side Effects <input type="radio"/> Need Refill <input type="radio"/> Don't Want to take Meds <input type="radio"/> Other _____	<input type="radio"/> Cost <input type="radio"/> Forgot to take <input type="radio"/> Side Effects <input type="radio"/> Need Refill <input type="radio"/> Don't Want to take Meds <input type="radio"/> Other _____	<input type="radio"/> Cost <input type="radio"/> Forgot to take <input type="radio"/> Side Effects <input type="radio"/> Need Refill <input type="radio"/> Don't Want to take Meds <input type="radio"/> Other _____
5. Do you check your <b>BLOOD PRESSURE</b> when you are not at the doctor's office <i>(at home, at pharmacy, or at a store, etc.)</i> ?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		
5a. If no, provide reason:	<input type="radio"/> No, never told to check <input type="radio"/> No, don't know how to check <input type="radio"/> No, don't have equipment		
5b. If yes, how often do you check your <b>BLOOD PRESSURE</b> :	<input type="radio"/> Multiple times a day <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> A few times per week <input type="radio"/> Monthly <input type="radio"/> DK*		
5c. If yes, do you share your <b>BLOOD PRESSURE</b> numbers with your doctor that you take at home, the pharmacy or a store?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*		

<b>HEART</b>	1. Have you been <b>diagnosed</b> by a healthcare provider as having <b>any</b> of these conditions: <i>(mark all that apply)</i>	
	Coronary Heart Disease/Chest Pain: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Congenital Heart Defects: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Heart Failure: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Stroke/Transient Ischemic Attack (TIA): <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Vascular Disease: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK* Heart Attack: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*	
	2. Are you taking <b>aspirin daily</b> to help prevent a heart attack or stroke?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> DK*

<b>SMOKING</b>	1. Do you <b>smoke</b> ? Includes cigarettes, pipes, or cigars <i>(smoked tobacco in any form)</i>	<input type="radio"/> Current Smoker <input type="radio"/> Quit (1-12 months ago) <input type="radio"/> Quit (More than 12 months) <input type="radio"/> Never Smoked
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\*DK - Don't Know/Not Sure

# Client Information & Healthy Lifestyle Questionnaire

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

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DAILY LIFE	1. Thinking about your <b>physical health</b> , which includes physical illness and injury, on how many days during the past <b>30 days</b> was your physical health <b>not good</b> ?	_____ Days	<input type="radio"/> DK*
	2. Thinking about your <b>mental health</b> , which includes stress, depression, and problems with emotions, on how many days during the past <b>30 days</b> was your mental health <b>not good</b> ?	_____ Days	<input type="radio"/> DK*
	3. During the past <b>30 days</b> , on about how many days did poor physical or mental health keep you from doing your <b>usual activities</b> , such as self-care, work, or recreation?	_____ Days	<input type="radio"/> DK*
	4. Are you limited in any activities because of physical, mental or emotional problems?	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> DK*
	5. Do <b>you now have</b> any health problems that requires you to use <b>special equipment</b> , such as a cane, a wheelchair, a special bed or a special telephone?	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> DK*
	5a. If yes, what <b>type of disability</b> ?	<input type="radio"/> Emotional <input type="radio"/> Physical	<input type="radio"/> Intellectual <input type="radio"/> Sensory
	6. Over the past 2 weeks, <b>how often</b> have you been bothered by any of the following problems: 6a. <b>Little interest or pleasure in doing things:</b>	<input type="radio"/> Not at all <input type="radio"/> More than half	<input type="radio"/> Several days <input type="radio"/> Nearly every day
6b. <b>Feeling down, depressed, or hopeless:</b>	<input type="radio"/> Not at all <input type="radio"/> More than half	<input type="radio"/> Several days <input type="radio"/> Nearly every day	

SAFETY & WELLNESS	1. How many days in the last week have you had a <b>drink containing alcohol</b> ?	<input type="radio"/> Never <input type="radio"/> DK*	_____ Days
	1a. On days that you had a drink containing alcohol, <b>how many drinks</b> did you have? <i>(one drink contains 14 grams of pure alcohol, which is found in: 12 ounces of regular beer, 5 ounces of wine or 1.5 ounces of distilled spirits)</i>	<input type="radio"/> Never <input type="radio"/> DK*	_____ Drinks
	2. If you are a <b>woman</b> , how many days in the past year have you had 4 or more alcoholic drinks in a day?	<input type="radio"/> Never <input type="radio"/> NA* <input type="radio"/> DK*	_____ Days
	3. If you are a <b>man</b> , how many days in the past year have you had 5 or more alcoholic drinks in a day?	<input type="radio"/> Never <input type="radio"/> NA* <input type="radio"/> DK*	_____ Days
	4. During the past 12 months, have you had a <b>flu shot or flu mist</b> ?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> DK*	
	4a. If not, please share why?		
5. Have you had a <b>pneumonia shot</b> ?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> DK*		
6. When did you last visit a <b>dentist or a dental clinic</b> for any reason?	<input type="radio"/> Within past year <input type="radio"/> Within past 2 years <input type="radio"/> 2 or more years ago <input type="radio"/> Never <input type="radio"/> DK*		

\*NA - Not Applicable \*DK - Don't Know/Not Sure

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Great Job! You Are Done! → 7**

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

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



**Websites:** [www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth)  
[www.dhhs.ne.gov/crc](http://www.dhhs.ne.gov/crc)

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

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



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