**Medical University of South Carolina**

**Hollings Cancer Center**

**Mobile Health Unit Patient Demographic Sheet**

(Please print clearly and complete the entire form)

\*PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street (APT#) City State Zip Code

\*AGE\_\_\_\_\_\_\_\_ \*SEX\_\_\_\_\_\_ \*SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*TELEPHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Are you Hispanic? Yes s NO

\*Which of these bests describe you?

\_\_African American or Black

\_\_American Indian or Alaskan Native

\_\_Asian

\_\_Caucasian or White

\_\_Pacific Islander

\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Do your breast have:

\_\_ pain

\_\_ lumps

\_\_ discharge

\_\_ implants

\_\_ previous breast cancer diagnosis

\_\_ no symptoms

\*Is there any chance that you are pregnant? \_\_\_\_Yes \_\_\_\_ No

\*Are you breastfeeding? \_\_\_\_Yes \_\_\_\_ No

\*What was the date of your last mammogram? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Do you have a family physician or health care provider? \_\_\_\_Yes \_\_\_\_No

\*Family physician or health care provider name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Do you have health insurance? \_\_\_ Yes ­\_\_\_No

\*Name of insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Policy ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_