



Project WISH—Women Into Staying Healthy
 DC Breast and Cervical Cancer Early Detection Program
 D.C. Department of Health
 825 N. Capitol Street, NE
 Washington, DC 20002 (202) 442-5900

WISH ID#

PROJECT WISH APPLICATION FORM

Incomplete application will not be considered for enrollment

**** DO NOT COMPLETE THIS FORM IF YOU HAVE HEALTH INSURANCE ****

LAST NAME		FIRST NAME		MI	TODAY'S DATE	
ADDRESS				APT#		DATE OF BIRTH
CITY		STATE		ZIP CODE		AGE
HOME PHONE			WORK PHONE			
SOCIAL SECURITY #		MAIDEN NAME		CELL-PHONE		EMAIL-ADDRESS
EMERGENCY CONTACT AND RELATIONSHIP				PHONE		
WHAT IS YOUR HOUSEHOLD MONTHLY INCOME? _____		HOW MANY PEOPLE DOES THAT INCOME SUPPORT? _____		COUNTRY OF BIRTH: _____		
				YEARS IN USA: _____		
RACE (check all that apply) <input type="checkbox"/> Black/ African American <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American/ Alaskan Native <input type="checkbox"/> Unknown		ARE YOU HISPANIC OR OF HISPANIC ORIGIN? Yes: <input type="checkbox"/> Hispanic/Black <input type="checkbox"/> Hispanic/White <input type="checkbox"/> No		PRIMARY LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Hindi/Urdu <input type="checkbox"/> French <input type="checkbox"/> Amharic <input type="checkbox"/> Mandarin <input type="checkbox"/> Arabic <input type="checkbox"/> Other _____		
HIGHEST GRADE COMPLETED 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 16+		DO YOU HAVE BREAST SYMPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		HOW DID YOU HEAR ABOUT PROJECT WISH? <input type="checkbox"/> Poster/Flyer <input type="checkbox"/> At Work <input type="checkbox"/> Doctor/Nurse Clinic <input type="checkbox"/> Radio <input type="checkbox"/> Outreach Worker <input type="checkbox"/> At Church <input type="checkbox"/> Friend/Relative <input type="checkbox"/> TV <input type="checkbox"/> Newspaper <input type="checkbox"/> Pamphlet		
DATE OF LAST MENSTRUAL PERIOD: _____ <input type="checkbox"/> Unknown		DO YOU HAVE BREAST IMPLANTS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
HAVE YOU EVER HAD A PAP SMEAR? <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Yes If Yes, Date: _____ WHERE _____ <input type="checkbox"/> Within the past year (1-12 months) <input type="checkbox"/> Within the past 2 years (1-2 years ago) <input type="checkbox"/> Within the past 3 years (2-3 years ago) <input type="checkbox"/> Within the past 5 years (3-5 years ago) <input type="checkbox"/> Over 5 years ago <input type="checkbox"/> Don't know			HAVE YOU EVER HAD A MAMMOGRAM? <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Yes If Yes, Date: _____ WHERE _____ <input type="checkbox"/> Within the past year (1-12 months) <input type="checkbox"/> Within the past 2 years (1-2 years ago) <input type="checkbox"/> Within the past 3 years (2-3 years ago) <input type="checkbox"/> Within the past 5 years (3-5 years ago) <input type="checkbox"/> Over 5 years ago <input type="checkbox"/> Don't know			
HAS YOUR MOTHER, SISTER, DAUGHTER, OR AUNT EVER HAD CERVICAL CANCER? <input type="checkbox"/> Yes, Relationship: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			HAS YOUR MOTHER, SISTER, DAUGHTER, AUNT OR GRANDMOTHER EVER HAD BREAST CANCER? <input type="checkbox"/> Yes, Relationship: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			
HAVE YOU EVER HAD: <input type="checkbox"/> A hysterectomy Date: _____ <input type="checkbox"/> Cervical Cancer Date: _____ <input type="checkbox"/> Breast Cancer Date: _____ <input type="checkbox"/> Ovarian Cancer Date: _____			DO YOU REQUIRE ANY SPECIAL ACCOMODATIONS DUE TO A DISABILTLITY? (optional) <input type="checkbox"/> Yes; please explain: _____ _____ <input type="checkbox"/> No			
DO YOU SMOKE? <input type="checkbox"/> NO <input type="checkbox"/> YES; If yes, are you interesting in classes to help you quiet smoking? <input type="checkbox"/> YES NO <input type="checkbox"/>						