MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)

PATIENT HISTORY

(TO BE COMPLETED BY CLIENT AND REVIEWED ANNUALLY)

P.O. BOX 570
JEFFERSON CITY, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE/SATELLITE CLINIC (IF ANY)	DATE OF VISIT (MM/DD/YYYY)

A. PERSONAL HISTORY

NAME (LAST, FIRST, MIDDLE INITIAL	MAIDEN NAME

E-MAIL ADDRESS	HOME PHONE NO.	WORK PHONE NO.	CELL PHONE NO.
	( )	( )	( )

STREET ADDRESS	CITY/STATE	ZIP CODE	COUNTY

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER (OPTIONAL)	WHAT IS THE PRIMARY LANGUAGE SPOKEN IN YOUR HOME?
		☐ English ☐ Spanish ☐ Other _____

NUMBER OF HOUSEHOLD MEMBERS	INSURANCE COVERAGE	MEDICAID DCN/MEDICARE NUMBER
	☐ None ☐ Mo HealthNet ☐ Medicare ☐ Private	

MILITARY STATUS

Have you or an immediate family member ever served in the U.S. Armed Forces? ☐ Yes ☐ No

If yes, would you like information about military-related services in Missouri? ☐ Yes ☐ No

RACE: (MUST BE ANSWERED, CHOOSE ALL THAT APPLY)

- ☐ (1) White
- ☐ (2) Black or African American
- ☐ (3) Asian
- ☐ (4) Native Hawaiian or Other Pacific Islander
- ☐ (5) American Indian or Alaskan Native
- ☐ (6) Other _____
- ☐ (7) Unknown (please avoid using)

ETHNICITY: (MUST BE ANSWERED.)

Are you of Hispanic origin? ☐ Yes ☐ No

HIGHEST GRADE OF SCHOOL COMPLETED (CIRCLE ONE)
(U.S. EQUIVALENT IF EDUCATED IN ANOTHER NATION)

1 2 3 4 5 6 7 8

9 10 11 12 13 14 15 16

HOW DID YOU HEAR ABOUT THE SHOW ME HEALTHY WOMEN PROGRAM?
(PLEASE CHOOSE ONLY ONE)

- ☐ (1) Physician/NP
- ☐ (2) Clinic/Health Center
- ☐ (3) Television
- ☐ (4) Radio/Podcast
- ☐ (5) Printed Ad/Newspaper
- ☐ (6) Billboard/Banner
- ☐ (7) Bus Sign
- ☐ (8) Health Care Provider
- ☐ (9) Health Fair/Relay Event
- ☐ (10) Health Coalition/Local Organization
- ☐ (11) Community Health Worker/Outreach
- ☐ (12) Relative/Friend
- ☐ (13) Faith Home/Church
- ☐ (14) Financial Counselor/ Registration
- ☐ (18) Social Media (Facebook, Instagram, Twitter, etc.)
- ☐ (16) Case/Care Manager/ Navigator
- ☐ (17) Internet/Online/Google Search
- ☐ (15) Other Location (Specify) _____

WHAT TYPE OF TRANSPORTATION DID YOU USE TO GET TO YOUR CLINIC APPOINTMENT?
(PLEASE CHOOSE ONLY ONE)

- ☐ (1) Bus
- ☐ (2) Van/Shuttle
- ☐ (3) OATS Bus
- ☐ (4) Taxi
- ☐ (5) Personal Vehicle
- ☐ (6) Relative/Friend
- ☐ (7) SMTS
- ☐ (8) Other _____

DATE OF LAST PAP TEST (MM/DD/YYYY)	DATE OF LAST MAMMOGRAM (MM/DD/YYYY)

DO YOU USE TOBACCO PRODUCTS? ☐ Yes ☐ No

HOW OFTEN DO YOU USE TOBACCO PRODUCTS?

☐ Everyday ☐ Some days ☐ Not at all ☐ Don't know

WHICH TYPE OF TOBACCO PRODUCT DO YOU USE? CHECK ALL THAT APPLY

☐ Tobacco Products ☐ Smokeless Tobacco Products

☐ Electronic Tobacco Products

B. CONTACTS: Name and phone numbers of two people who can always reach you

NAME	HOME PHONE WITH AREA CODE	WORK PHONE
	( )	( )
NAME	HOME PHONE WITH AREA CODE	WORK PHONE
	( )	( )