

	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. () ()
STREET ADDRESS	CITY/STATE	ZIP CODE
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: ☐ None ☐ Mo HealthNet ☐ Medicare ☐ Private	MEDICAID DCN/MEDICARE NUMBER
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) Print 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 ☐ (15) Other Location (specify) _____ ☐ (16) Case/Care Manager, Navigator ☐ (17) Internet/Online/Google Search ☐ (18) Social Media (Facebook, Instagram, Twitter, etc.)		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 now smoke cigarettes? ☐ Everyday ☐ Some days ☐ Not at all ☐ Don't know		
Name and telephone 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 () _____