Cervical History & Exam Documentation

Patient Name	DOB / /	Exam Date / /

Gynecologic Health History

Pertinent Personal Medical Hx:

Purpose of Today's Visit
- ☐ Routine screening
- ☐ Short-term follow-up
- ☐ Patient concerns ________________
- ☐ Other ________________

Cervical Cancer Screening History
Most recent screening Date __/__/__ In last 5 yrs? ☐ Yes ☐ No ☐ Unk
Test ☐ Pap ☐ Pap+HPV *(age 30+ only)* Result__________________
History CIN 2+ ☐ Yes __/__/__ ☐ No ☐ Unk Notes__________________
History treatment? ☐ Yes __/__/__ ☐ No ☐ Unk __________________

Menstrual/Pregnancy Hx
Last menstrual period_________
☐ Regular ☐ Irregular
Menopause ☐ Yes ☐ No
Gravida ________ Para_______
SAB ___________ TAB _______
Age at first live birth ________

Sexual History
Age at first intercourse __________
No. of sexual partners __________
Pain with intercourse ☐ Yes ☐ No
Post coital bleeding ☐ Yes ☐ No
Curr birth ctrl meth ______________
OCP use ever ☐ Yes ☐ No
If Yes ➔ No. of yrs __________

Pelvic History
Hx of vaginitis/PID ☐ Yes ☐ No ☐ Unknown
Hx of STI ☐ Yes ☐ No ☐ Unknown
☐ Gonorrhea ☐ Chlamydia ☐ Syphilis ☐ HPV ☐ HIV
☐ Trichomonas ☐ Herpes ☐ Other______________
Vaginal symptoms ☐ Itching ☐ Discharge ☐ Lesions
☐ Spotting ☐ Pain with urination
Hysterectomy ☐ Yes ☐ No Date_____________

Other Risk Factors
Smoking ☐ No ☐ Yes ______ packs/day ______ yrs
Immunosuppressed ☐ No ☐ Yes
Family Hx cancer ☐ No ☐ Yes Type____________________
Personal Hx cancer ☐ No ☐ Yes Type____________________
DES exposure ☐ No ☐ Yes ☐ Unknown

Patient Education
- ☐ Risk reduction
- ☐ Rescreening
- ☐ Smoking cessation
  If Yes ➔ Cessation resource referral ☐ Yes ☐ No
- ☐ Other ______________________

Pelvic Exam

Examination

	Normal	Abnormal	Comment
Abdomen	☐	☐	____________________
Vulva	☐	☐	____________________
Perineum	☐	☐	____________________
Vagina	☐	☐	____________________
Cervix	☐	☐	____________________
Uterus	☐	☐	____________________
Adnexa	☐	☐	____________________
Rectum	☐	☐	____________________

Pap Test Performed Today ☐ Yes ☐ No

Indicate Location of Abnormality

Results
- ☐ No abnormalities identified
- ☐ Abnormal findings on history or exam ______________________

Additional Comments

Clinician Signature: ______________________ **Date**: __/__/__

Cervical Cancer Screening Results
Pap test ☐ Normal ☐ Abnormal ☐ Unsatisfactory
If normal ➔ EC/TZ component absent? ☐ Yes ☐ No
If abnormal ➔ ☐ ASC-US ☐ LSIL ☐ ASC-H ☐ HSIL
☐ AGC *specify:* __________ ☐ AIS
☐ CIS ☐ Other __________
If ASC-US ➔ Reflex HPV result ☐ Positive ☐ Negative
HPV (if cotest performed) ➔ ☐ Positive ☐ Negative
Other findings not related to neoplasia______________
Date Reviewed __/__/__

Care Plan
- ☐ Routine screening: ☐ 3yrs (Pap only) ☐ 5yrs (cotest only)
- ☐ Spec pop routine screening: ☐ 1yr ☐ Other______________
- ☐ Repeat Pap: ☐ 6mo ☐ 12mo ☐ Other______________
- ☐ HPV testing Date __/__/__ Result ______________
- ☐ HPV Genotyping§ Date __/__/__ Result ______________
- ☐ Colposcopy Date __/__/__ Result ______________
- ☐ Gyn/Surg consult Date __/__/__ Result ______________

§ *HPV Genotyping is not a covered benefit of the Every Woman Counts program*

Clinician Signature: ______________________ **Date**: __/__/__

Patient Notification
- ☐ Patient notified of screening results
- ☐ Patient scheduled/referred for additional services

Clinician or Staff Signature: ______________________
Date: __/__/__