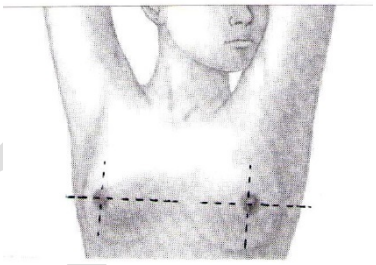
_____ (BCCCP Provider) **BCCCP Physical Exam Record**

Pt. Name: _____ **Date:**_____

Patient Education: **BSE:** _____ taught_____ reviewed _____refused **Rescreening Ed:**_____.

Breasts	**WNL**	**Lt**	**Rt**	
• Asymmetry				☐ Fixed Size:
• Skin Abnormality				☐ Mobile Depth:
• Nipple Retraction				☐ Soft
• Lymphadenopathy				☐ Hard
• Nipple Discharge				☐ Other:
• Lump/Thickening				



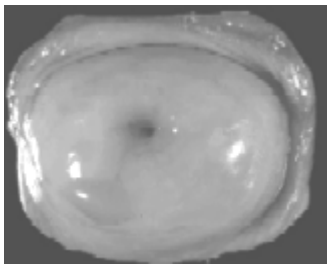
Comments:

Cervical cancer screening: Date of last screening: _____
Last screening result: _____

☐ Done/Completed ☐ Not Performed

☐ Performed Elsewhere ☐ Refused

Pelvic/Bimanual	**WNL**	**ABN**
External genitalia		
• Lesions		
• Swelling		
• Discharge		
Vagina		
• Abnormal color, texture, lesion		
• Discharge		
Cervix		
• Present		
• Abnormal Color/Texture		
Uterus		
• Present		
• Palpable		
• Abnormal Position/Size		
Adnexae		
• Ovaries Present		
• Ovaries Palpable		
• Tenderness		
Rectovaginal		
• Skin Abnormality		
• Mass		



Signature: _____ Date: _____

Return Date for Rescreening: _____

Referrals, Results & Follow-up: **Mammogram Referral: Screening** _____ **Diagnostic** _____
Appointment Date: _____ **Refused** _____
Mammogram Result:_____ **Mammogram Follow-Up:**_____

Cervical Cancer Screening Result: _____
Follow-up: _____
_____

SIGNATURE: _____ **DATE:** _____

Revised 03/15/2019

_____**(BCCCP Provider)** **BCCCP MEDICAL HISTORY RECORD**

Name:_____ Date: _____ Screening Cycle: ☐New ☐Rescreen

Primary Care Provider:_____ Phone:(Optional) _____

Reason for Visit: _____ BP(Opt. Non-BCCCP service)_____

BREAST HISTORY

Last CBE: _____ Provider:_____

Last Mammogram: ☐Never ☐Annually Date Last Performed: _____Provider:_____

Recent Breast Symptoms: ☐None ☐Lump ☐Nipple discharge ☐Skin changes ☐Pain
☐Other:_____

Risk Assessment: ☐Personal history of breast cancer ☐Known genetic mutation (BRCA 1 or 2)
☐1st degree relative with history of premenopausal breast cancer
☐History of radiation treatment to chest before age 30 ☐Lifetime risk ≥ 20%
☐Unable to Answer ☐ History Unknown

Previous History of Breast Problems:

Breast Surgery or Biopsy: ☐None ☐R ☐L Specify type:_____ Date:_____

Implants: ☐ R ☐ L Date Removed: _____

Breast Cancer Treatment: _____

BSE done: ☐Never ☐Monthly

GYNECOLOGICAL/OBSTETRICAL HISTORY

LMP: _____ Age @ menarche: _____ Age @ menopause: _____

Cervical cancer screening history: ☐Every 3 years ☐Every 5 years ☐Never (greater than 10 years)

Date of last cervical cancer screening: _____

Risk Assessment: ☐History of cervical cancer or pre-cancer ☐DES exposure *in utero*
☐Immunocompromised due to organ transplantation
☐Immunocompromised from another health condition
☐Tests positive for HIV infection ☐History Unknown

Hysterectomy: ☐Y ☐N Date: _____ Cervix Removed: ☐Y ☐N Ovaries removed: ☐Y ☐N

Laser/cryosurgery: ☐Y ☐N Date: _____

Smoking History: ☐None ☐Smoked for how long: _____ Amount:_____

Colon Cancer Screening: ☐None ☐FIT/FOBT ☐Flex sig. ☐Colonoscopy Date of last exam:_____

REFERRALS: Smoking: _____ **Nutrition/Physical Activity:** _____

Colon Cancer Screening: _____ **Other:** _____

Signature: _____ Date: _____