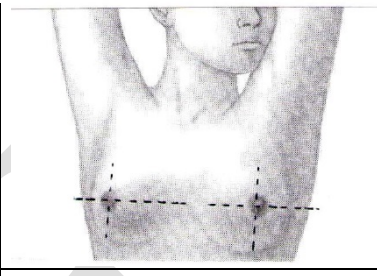


Pt. Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Education: BSE: \_\_\_\_\_ taught \_\_\_\_\_ reviewed \_\_\_\_\_ refused Rescreening Ed: \_\_\_\_\_

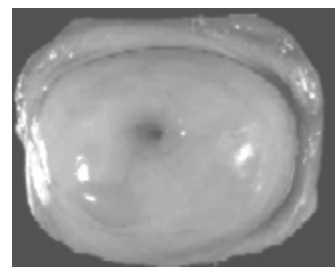
Breasts	WNL	Lt	Rt	
• Asymmetry				<input type="checkbox"/> Fixed Size:
• Skin Abnormality				<input type="checkbox"/> Mobile Depth:
• Nipple Retraction				<input type="checkbox"/> Soft
• Lymphadenopathy				<input type="checkbox"/> Hard
• Nipple Discharge				<input type="checkbox"/> Other:
• Lump/Thickening				



Comments: \_\_\_\_\_

**Cervical cancer screening:** Date of last screening: \_\_\_\_\_  
 Last screening result: \_\_\_\_\_  
 Done/Completed     Not Performed  
 Performed Elsewhere     Refused

Pelvic/Bimanual	WNL	ABN
<b>External genitalia</b>		
• Lesions		
• Swelling		
• Discharge		
<b>Vagina</b>		
• Abnormal color, texture, lesion		
• Discharge		
<b>Cervix</b>		
• Present		
• Abnormal Color/Texture		
<b>Uterus</b>		
• Present		
• Palpable		
• Abnormal Position/Size		
<b>Adnexae</b>		
• Ovaries Present		
• Ovaries Palpable		
• Tenderness		
<b>Rectovaginal</b>		
• 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: \_\_\_\_\_

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Cervical Cancer Screening Result: \_\_\_\_\_  
 Follow-up: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_(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)  
1<sup>st</sup> degree relative with history of premenopausal breast cancer  
History of radiation treatment to chest before age 30 Lifetime risk  $\geq$  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: \_\_\_\_\_