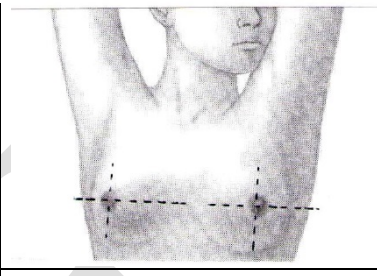


Pt. Name: _____ Date: _____

Patient Education: BSE: _____ taught _____ reviewed _____ refused Rescreening Ed: _____

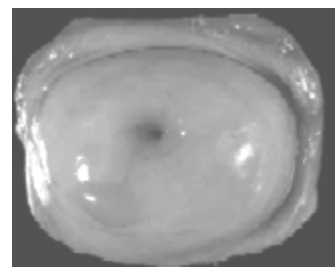
Breasts	WNL	Lt	Rt	
• Asymmetry				<input type="checkbox"/> Fixed Size:
• Skin Abnormality				<input type="checkbox"/> Mobile Depth:
• Nipple Retraction				<input type="checkbox"/> Soft
• Lymphadenopathy				<input type="checkbox"/> Hard
• Nipple Discharge				<input type="checkbox"/> Other:
• Lump/Thickening				



Comments: _____

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

Pelvic/Bimanual	WNL	ABN
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: _____

_____(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 \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: _____