West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH | Office of Maternal, Child and Family Health

West Virginia Breast and Cervical Cancer Screening Program

Medical History Form

West Virginia Breast & Cervical Cancer Screening Program — You're Worth It

Name: _____ **Social Security Number:** _____

Telephone: _____ **Marital Status:** ☐ S ☐ M ☐ W ☐ D **Date of Birth:** _____

Family Physician: _____ **Date of Last Visit:** _____ **Age:** _____

Medications: _____ **Current Illness (if any):** _____

Personal History *(Check all that apply)*

- ☐ Allergies
- ☐ Surgery
- ☐ Epilepsy/Seizure
- ☐ Mental Illness
- ☐ Thyroid Disease
- ☐ Breast Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Circulatory Problems
- ☐ Varicose Veins
- ☐ Lung Problems/ TB
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Hormone Problems
- ☐ Ovaries, Tubes, Uterine
- ☐ Vaginal Infections
- ☐ STD
- ☐ Cancer
- ☐ Alcohol/Drugs
- ☐ Tobacco use
- ☐ Multiple Sex Partners

Age of first intercourse: _____

Gynecologic and Obstetric History

Age of first period: _____

Age of Menopause: _____

Are your Period:
☐ Regular ☐ Irregular
☐ Light ☐ Moderate ☐ Heavy

Do you miss Period: ☐ Yes ☐ No

Sever Cramping: ☐ Yes ☐ No

First Day of Last Period: _____

Pain/Bleeding with intercourse: ☐ Yes ☐ No

Ever had a Pap test? ☐ Yes ☐ No

Pap test Result: ☐ Normal ☐ Abnormal

Number of Children Breastfed: _____

Previous Contraception Method: _____

Current Contraception Method: _____

Gravida: _____

Para: _____

Tubal Ligation: ☐ Yes ☐ No

Hysterectomy: ☐ Yes ☐ No

Ever had a Mammogram? ☐ Yes ☐ No

Mammogram Result: ☐ Normal ☐ Abnormal

Family History (Check all that apply)

- ☐ Ovarian Cancer
- ☐ Breast Cancer
- ☐ Other Cancers
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Mother received DES when Pregnant with you

Education/Counseling

☐ Cancer ☐ Risk Factors
☐ Breast Health Awareness

Methods:
☐ Group
☐ One:One
☐ Videos
☐ Literature

Visit Type: _____

Weight: _____ **Height:** _____ **BP:** _____ **LMP:** _____

In the Past 48 Hours, have you done any of the following? (Check all that apply)

☐ Douche ☐ Tampons ☐ Intercourse ☐ Spermicide/Vaginal Cream

Pap Test Results Reported to Patient:

_____
_____
_____
_____

Date: _____

Method: _____

Female: _____

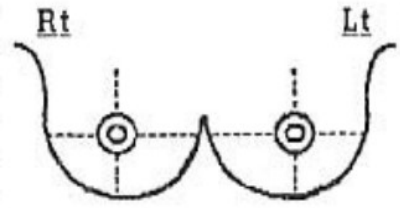
Vagina _____

Cervix _____

Uterus _____

Adnexa _____

Breast _____



Mammography Results Reported to Patient:

_____
_____
_____
_____

Date: _____

Method: _____

Title: _____

Signature: _____ Date: _____