WV Breast & Cervical Cancer Screening Program

West Virginia Department of Health & Human Resources
Office of Maternal, Child & Family Health

Medical History

Name:		Social Security Number:	
Telephone:	Marital Status: S M W D	Date of Birth: / /	Age:
Family Physician:		Date of Last Visit: / /	
Medications:			
Current Illness (if any):			

Personal History/Problems

	Yes	No
Allergies		
Surgery		
Headaches		
Epilepsy/Seizures		
Mental Illness		
Thyroid Disease		
Breast Problems		
Heart Problems		
High Blood Pressure		
Circulatory Problems		
Varicose Veins		
Lung Problems/Tuberculosis		
Liver Disease/Hepatitis		
Kidney Disease		
Diabetes		
Hormone Problems		
Ovaries, Tubes, Uterus		
Vaginal Infections		
Sexually Transmitted Disease		
Cancer		
Alcohol/Drugs		
Smoke		
Breast Implants		
Multiple Sex Partners		
Age of First Intercourse		

Menstrual History

Age when periods first started _____
Age of Menopause (if applicable) _____
How often do you have your periods? _____
Are your periods ___ Regular ___ Irregular
___ Light ___ Moderate ___ Heavy
Do you miss periods? _____
Severe Cramping? _____
First Day of last period _____
Pain/bleeding with intercourse _____
Hysterectomy _____
Tubal Ligation _____
Have you ever had a Pap smear? _____
Was it normal or abnormal? _____
Have you ever had a Mammogram? _____
Was it normal or abnormal? _____

Contraceptive History

Previous birth control method(s)
_____
_____
Current Method _____

Family History

	Yes	No
Breast Cancer		
Ovarian Cancer		
Other Cancers		
Did Your Mother Receive DES When Pregnant With You?		
Diabetes		
Heart Disease		
Hypertension		

Pregnancy History

Gravida _____ Para _____
Age first pregnancy _____
Number of children breast fed _____

Nurse's Notes

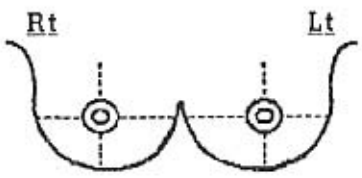
_____
_____
_____

Signature/Title _____ Date / /

Visit Type:	Weight:	Height:	B/P:	LMP:

In the Past 48 Hours:
___ Douche ___ Tampons ___ Intercourse ___ Spermicide/Vaginal Cream

Female:	
Vagina	
Cervix	
Uterus	
Adnexa	
Breast	



Education/Counseling

___ Group ___ One:One ___ Videos ___ Literature
___ Cancer ___ Breast Self-Examination ___ Risk Factors

PAP Results Reported to Patient

Results: _____
Date: _____ Method: _____

Mammography Results Reported to Patient

Results: _____
Date: _____ Method: _____

Clinician Findings/Clinician Orders

_____
_____

Signature/Title _____ Date: / /