

## Breast & Cervical Health Check Annual Screening Data Collection Form

Clinic:		Medical Record #:	
Last Name:		First Name:	MI:
Social Security #:	Date of Birth: - -	Date of Exam: - -	
<b>HISTORY</b>		<b>CERVICAL HISTORY</b>	
Client reports prior mammogram <input type="checkbox"/> No <input type="checkbox"/> Yes, on ____ - ____ - ____  <input type="checkbox"/> Client has had breast cancer		Has client had a Pap within the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes last Pap on ____ - ____ - ____  <input type="checkbox"/> Client has had cervical cancer <input type="checkbox"/> Client has had a hysterectomy	
<b>BREAST CANCER SCREENING</b>		<b>CERVICAL CANCER SCREENING</b>	
Breast symptoms led to this visit (ie, pain, lump, client concern) <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> CBE not needed – normal exam past 12 months <input type="checkbox"/> CBE refused or needed but not done  <input type="checkbox"/> <b>CBE done this visit</b>		<input type="checkbox"/> <b>Pelvic Exam</b> done this visit <input type="checkbox"/> Pelvic not needed, normal exam past 12 months <input type="checkbox"/> Pelvic refused or needed but not done  <input type="checkbox"/> Pap not needed, recent normal or history of normal <input type="checkbox"/> Pap refused or needed but not done <input type="checkbox"/> Pap done by other provider. Submit cytology report, or test done ____ - ____ - ____, results noted below  <input type="checkbox"/> <b>Pap test done this visit</b> Type: <input type="checkbox"/> Conventional Smear <input type="checkbox"/> Liquid Based <input type="checkbox"/> Other Reason done: <input type="checkbox"/> Routine screening <input type="checkbox"/> Surveillance after prior abnormality	
<b>EXAMINING CLINICIAN MUST COMPLETE:</b> <b>CBE Result:</b> <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding probable (e.g. abscess, mastitis and other conditions.) Further evaluation at clinician discretion. <input type="checkbox"/> Suspicious for cancer. (e.g., nipple or areolar scaliness, spontaneous bloody or serous nipple discharge.) <b>Cancer must be ruled out.</b>		<b>Pap test results: *</b> <input type="checkbox"/> Negative <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL Includes HPV changes <input type="checkbox"/> HSIL Includes CIS <input type="checkbox"/> Squamous Cell Cancer <input type="checkbox"/> AGC (Atypical Glandular Cells) <input type="checkbox"/> AIS (Endocervical Adenocarcinoma In Situ) <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Unsatisfactory for evaluation	
For <b>Screening Mammogram:</b> Reason done/ordered: <input type="checkbox"/> Routine screening <input type="checkbox"/> Surveillance after prior abnormality  Result * of Mammogram performed ____ - ____ - ____  <input type="checkbox"/> 1 – Negative <input type="checkbox"/> 2 – Benign findings <input type="checkbox"/> 3 – Probably benign, short interval follow up indicated <input type="checkbox"/> 4 – Suspicious abnormality, biopsy should be considered <input type="checkbox"/> 5 – Highly suggestive of malignancy, appropriate action should be taken 0 – Assessment incomplete, <u>and</u> <input type="checkbox"/> – need additional imaging, or <input type="checkbox"/> – need comparison with prior imaging  Final Imaging result: ____ (1-5)  Next mammogram or CBE due: ____ - ____ (mo/yr)		<b>HPV high risk panel test: *</b>  Test done on ____ - ____ - ____ with result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive  Next Pap test due: ____ - ____ (mo/yr)	

\* Can send imaging/laboratory report, or instruct mammography center/laboratory to send report to BCHC