

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PROVIDER:** \_\_\_\_\_ **CLINIC:** \_\_\_\_\_ **DOS:** \_\_\_\_\_

**MEDICAL HISTORY**

**CERVICAL HEALTH HISTORY: Have you ever had a Pap test?**  Yes  No  Unknown  
**If yes, was your last Pap test more than 5 years ago?**  Yes  No  Unknown  
**Date of last Pap test (mm/dd/yyyy)** \_\_\_\_\_ **Results**  Normal  Abnormal  Unknown  
**Hysterectomy?**  Yes  No **If Yes, was it for CIN II/III or cervical cancer?**  Yes  No  Don't Know

**BREAST HEALTH HISTORY: Have you had a screening mammogram BEFORE enrollment in BCCHP?**  Yes  No  Unknown  
**If yes, date of prior screening mammogram (mm/dd/yyyy)** \_\_\_\_\_ **Results**  Normal  Abnormal  Unknown

**Do you identify as?**  Heterosexual  Lesbian  Bi-Sexual  Transgender **Do you have sexual contact with?**  Men  Women  Both  
**Do you have a disability?**  Yes  No **If Yes, does this disability make accessing BCCHP services difficult?**  Yes  No  
**Type of disability**  Mobility / physical  Hearing  Visual  Developmental  Other (specify) \_\_\_\_\_

**LMP (Date)** \_\_\_\_\_ **Post – Menopausal?**  Yes  No

**OTHER HEALTH INFORMATION BMI** \_\_\_\_\_  Current smoker  Referred to Tobacco Quit Line

**BREAST HEALTH HISTORY**

<b>AGES 40-64</b>	<b>Identified Risk Factors for Breast Cancer (check if yes):</b>	
	<input type="checkbox"/> Has your mother, sister, or daughter ever had breast cancer?	<input type="checkbox"/> Have you ever had breast cancer?
	<input type="checkbox"/> Do you have any pre-malignant biopsy history?	<input type="checkbox"/> Never given birth or first birth after age 30?
	<b>Has any relative on either side of your family had <u>breast</u> cancer before they were 50 years of age?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Has any relative on either side of your family had <u>ovarian</u> cancer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Have any of your male relatives ever had breast cancer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

**CERVICAL HEALTH HISTORY**

<b>AGES 40-64</b>	<b>Identified Risk Factors for Cervical Cancer (check if yes):</b>	
	<input type="checkbox"/> Abnormal Pap history	<input type="checkbox"/> History of HPV <input type="checkbox"/> HIV Positive

**BREAST EXAM/SCREENING**

<b>AGES 40-64</b>	<b>BREAST: Client Reports Breast Symptoms</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, specify</b> _____
	<b>CBE Performed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If No, Why</b> <input type="checkbox"/> Not Indicated / Not Needed <input type="checkbox"/> Other / Unknown <input type="checkbox"/> Refused
	<b>CBE Results:</b> <u>Normal/Benign</u> <input type="checkbox"/> Normal Exam <input type="checkbox"/> Benign Finding (specify) _____ <input type="checkbox"/> Implants <input type="checkbox"/> Absent Breast(s)
	<u>Suspicious for Breast Cancer</u> (*Diagnostic work-up required) <input type="checkbox"/> *Discrete Palpable Mass – Suspicious for Cancer <input type="checkbox"/> *Bloody or serous spontaneous nipple discharge <input type="checkbox"/> *Nipple or areolar scaliness <input type="checkbox"/> *Skin changes (dimpling, retraction, redness, swelling, heat)
	<b>Indication for Mammogram:</b> <input type="checkbox"/> Routine Screen <input type="checkbox"/> Evaluate symptoms, positive CBE, or previous abnormal mammogram <input type="checkbox"/> Referred by non-BCCHP provider for diagnostic evaluation
	<b>Mammogram not done:</b> <input type="checkbox"/> CBE only or direct for other imaging / diagnostic workup <input type="checkbox"/> Not needed / other <input type="checkbox"/> Refused
	<b>Refer for Mammogram</b> <input type="checkbox"/> Yes, Referred to _____
	<b>*Diagnostic Work-up Plan</b> <input type="checkbox"/> Biopsy <input type="checkbox"/> Cyst Aspiration <input type="checkbox"/> Diagnostic Mammogram <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Surgical Consultation / Repeat Breast Exam <input type="checkbox"/> Ultrasound <input type="checkbox"/> Breast Smear <input type="checkbox"/> Glactogram
	<b>*A mammogram (or additional mammographic views) is not sufficient evaluation of an abnormal CBE. Palpable breast masses need to be evaluated clinically and/or with additional imaging regardless of mammogram result.</b>

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ CLINIC: \_\_\_\_\_ DOS: \_\_\_\_\_

**CERVICAL EXAM/SCREENING**

AGES 40-64	<b>CERVICAL: Pelvic Exam Performed</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, Why? <input type="checkbox"/> Not Indicated/Not Needed <input type="checkbox"/> Other/Unknown <input type="checkbox"/> Refused				
	<b>Pelvic Exam Results:</b> <u>Normal/Negative</u> <u>Suspicious for Cervical Cancer</u> (*Diagnostic work-up required) <u>Other Finding</u>	<input type="checkbox"/> Normal	<input type="checkbox"/> *Visible Mass	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Infection
	<input type="checkbox"/> Absent Cervix	<input type="checkbox"/> *Suspicious lesions (white patch, wart)	<input type="checkbox"/> Unusual Discharge	<input type="checkbox"/> Polyp	
	<b>Indication for Pap Test:</b>	<input type="checkbox"/> Routine Screen	<input type="checkbox"/> Surveillance for previous abnormal pap	<input type="checkbox"/> Direct to diagnostic workup or HPV test	
		<input type="checkbox"/> Referred by non-BCCHP provider for diagnostic evaluation		<input type="checkbox"/> Not Needed / Other <input type="checkbox"/> Refused	
	<b>Pap Test Performed:</b>	<input type="checkbox"/> Conventional	<input type="checkbox"/> Liquid	Lab Name _____	
	<b>Specimen Adequacy:</b>	<input type="checkbox"/> Unknown	<input type="checkbox"/> Satisfactory	<input type="checkbox"/> Unsatisfactory (If Unsatisfactory, DO NOT MARK RESULT BELOW)	
	<b>Pap Test Results:</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> *High grade SIL (with features suspicious for invasion)		
		<input type="checkbox"/> ASC-US (HPV testing recommended)	<input type="checkbox"/> *Squamous cell cancer		
		<input type="checkbox"/> Low grade SIL (including HPV changes)	<input type="checkbox"/> *AGC (incl atypical, endocervical adenocarcinoma		
	<input type="checkbox"/> *ASC-H (Atypical squamous cells cannot exclude HSIL)	in situ and adenocarcinoma)			
<b>HPV Test Performed:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Date:</b> _____	<b>Result is</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant	
<b>*Diagnostic Work-up Plan:</b>	<input type="checkbox"/> Biopsy	<input type="checkbox"/> Consultation	<input type="checkbox"/> Colposcopy	<input type="checkbox"/> Colposcopy with Biopsy <input type="checkbox"/> LEEP <input type="checkbox"/> Conization	

Client Counseled/Taught About	Recommendations
<input type="checkbox"/> Risk of cervical neoplasia and/or breast cancer <input type="checkbox"/> Importance of screening exams (breast and cervical)	<input type="checkbox"/> Next Pap test due in _____ months <input type="checkbox"/> Next mammography/radiology due in _____ months

**SERVICES BILLED**

New BCCHP Client	Established BCCHP Client
<input type="checkbox"/> 99201 – Office brief new <input type="checkbox"/> 99386 – Prev new age 40-64 <input type="checkbox"/> 99202 – Office expand new <input type="checkbox"/> 99387 – Prev new age 65+ <input type="checkbox"/> 99203 – Office detail new	<input type="checkbox"/> 99211 – Office brief est <input type="checkbox"/> 99396 – Prev est age 40-64 <input type="checkbox"/> 99212 – Office expand est <input type="checkbox"/> 99397 – Prev est age 65+ <input type="checkbox"/> 99213 – Office detail est

PROVIDER SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

PLEASE PRINT NAME HERE

\_\_\_\_\_

**Provider Comments:**


PLEASE FAX BOTH PAGE 1 AND PAGE 2 TO BCCHP PRIME CONTRACTOR: (509) 667-7352