

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

| | | |
|-------------------|---|---|
| AGES 40-64 | Identified Risk Factors for Breast Cancer (check if yes): | |
| | <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? |
| | Has any relative on either side of your family had <u>breast</u> cancer before they were 50 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Has any relative on either side of your family had <u>ovarian</u> cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Have any of your male relatives ever had breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

CERVICAL HEALTH HISTORY

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

BREAST EXAM/SCREENING

| | |
|-------------------|--|
| AGES 40-64 | BREAST: Client Reports Breast Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, specify _____ |
| | CBE Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Why <input type="checkbox"/> Not Indicated / Not Needed <input type="checkbox"/> Other / Unknown <input type="checkbox"/> Refused |
| | CBE Results: <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) |
| | Indication for Mammogram: <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 |
| | Mammogram not done: <input type="checkbox"/> CBE only or direct for other imaging / diagnostic workup <input type="checkbox"/> Not needed / other <input type="checkbox"/> Refused |
| | Refer for Mammogram <input type="checkbox"/> Yes, Referred to _____ |
| | *Diagnostic Work-up Plan <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 |
| | *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. |

Client Name: _____ DOB: _____

PROVIDER: _____ CLINIC: _____ DOS: _____

CERVICAL EXAM/SCREENING

| | | | | |
|--|--|--|---|--|
| AGES 40-64 | CERVICAL: Pelvic Exam Performed <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 | | | |
| | Pelvic Exam Results: <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 | |
| | Indication for Pap Test: <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 | | | |
| | Pap Test Performed: <input type="checkbox"/> Conventional <input type="checkbox"/> Liquid Lab Name _____ | | | |
| | Specimen Adequacy: <input type="checkbox"/> Unknown <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory (If Unsatisfactory, DO NOT MARK RESULT BELOW) | | | |
| | Pap Test Results: <input type="checkbox"/> Negative | | | |
| | <input type="checkbox"/> ASC-US (HPV testing recommended) | <input type="checkbox"/> *High grade SIL (with features suspicious for invasion) | | |
| | <input type="checkbox"/> Low grade SIL (including HPV changes) | <input type="checkbox"/> *Squamous cell cancer | | |
| <input type="checkbox"/> *ASC-H (Atypical squamous cells cannot exclude HSIL) | <input type="checkbox"/> *AGC (incl atypical, endocervical adenocarcinoma in situ and adenocarcinoma) | | | |
| HPV Test Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date: _____ Result is <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminant | | | | |
| *Diagnostic Work-up Plan: <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

| <u>New BCCHP Client</u> | <u>Established BCCHP Client</u> |
|---|---|
| <input type="checkbox"/> 99201 – Office brief new <input type="checkbox"/> 99386 – Prev new age 40-64 | <input type="checkbox"/> 99211 – Office brief est <input type="checkbox"/> 99396 – Prev est age 40-64 |
| <input type="checkbox"/> 99202 – Office expand new <input type="checkbox"/> 99387 – Prev new age 65+ | <input type="checkbox"/> 99212 – Office expand est <input type="checkbox"/> 99397 – Prev est age 65+ |
| <input type="checkbox"/> 99203 – Office detail new | <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: (206) 296-0208