



Client Identification	Client History	Screening Measurements
Program # _____ ID # _____ Visit Date: ____/____/_____ (Earliest of 10a, 11a, 12a, 13a, 14a below) (mm / dd / yyyy) <input type="checkbox"/> Limited <input type="checkbox"/> Comprehensive Last Name _____ First Name _____ Middle Initial _____ Facility # _____ ANSI # _____ NPI # _____	1. High Risk for Breast Cancer? <input type="radio"/> 1. Yes <input type="radio"/> 2. No <input type="radio"/> 3. Not assessed/Unknown 2. High Risk for Cervical Cancer? <input type="radio"/> 1. Yes <input type="radio"/> 2. No <input type="radio"/> 3. Not assessed/Unknown 3. Has the woman ever had a pap test? <input type="radio"/> 1. Yes → 3a. Date previous: ____/____/_____ (month/year: Enter 06 if month unknown) <input type="radio"/> 2. No <input type="radio"/> 3. Unknown	4. Height ____ inches 5. Weight _____ pounds 6. Waist Circumference ____ inches 7. Hip Circumference ____ inches <input type="radio"/> Unable to obtain 8. Blood Pressure (two readings required): 8a. 1st Reading: ____ / ____ mmHg 8b. 2nd Reading: ____ / ____ mmHg *Avg. value > 180/or/110 needs immediate workup <input type="radio"/> Unable to obtain 9. Measurement Date: ____/____/_____ (mm / dd / yyyy)

Examination	Date Performed/Type	Result	Payer
10. Clinical Breast Exam <input type="radio"/> 1. Performed → <input type="radio"/> 2. Not performed <input type="radio"/> 3. Refused	10a. CBE Date ____/____/_____ (mm / dd / yyyy)	10b. CBE Result <input type="radio"/> 1. Normal or benign (including fibrocystic, lumpiness, or nodularity) <input type="radio"/> *2. Abnormality—suspicious for cancer	10c. CBE paid by <input type="radio"/> 1. BCCEDP <input type="radio"/> 2. Other <input type="radio"/> 3. Unknown <input type="radio"/> 4. BCCEDP / Insurance <input type="radio"/> 5. Insurance Only
11. Mammogram <input type="radio"/> 1. Performed; routine screening mammogram → <input type="radio"/> 2. Performed to evaluate symptoms, positive CBE, or previous abnormal mammogram → <input type="radio"/> 3. Performed, not paid by BCC; patient referred for DX Evaluation: DX referral date: ____/____/_____ <input type="radio"/> 4. Not performed <input type="radio"/> 5. Refused	11a. Mamm. Date ____/____/_____ (mm / dd / yyyy)	11b. Mammogram Result <input type="radio"/> 1. Negative (BI-RADS 1) <input type="radio"/> 2. Benign (BI-RADS 2) <input type="radio"/> 3. Probably benign—short interval follow-up indicated (BI-RADS 3) <input type="radio"/> *4. Suspicious abnormality— consider biopsy (BI-RADS 4) <input type="radio"/> *5. Highly suggestive of malignancy (BI-RADS 5) <input type="radio"/> *6. Need evaluation or Film comparison (BI-RADS 0)	11c. Mamm paid by <input type="radio"/> 1. BCCEDP <input type="radio"/> 2. Other <input type="radio"/> 3. Other <input type="radio"/> 4. Unknown <input type="radio"/> 5. BCCEDP / Insurance <input type="radio"/> 6. Insurance Only
12. Screening MRI <input type="radio"/> 1. Performed → <input type="radio"/> 2. Not performed <input type="radio"/> 3. Refused	12a. MRI Date ____/____/_____ (mm / dd / yyyy)	12b. MRI Result <input type="radio"/> 1. Negative (Category 1) <input type="radio"/> 2. Benign (Category 2) <input type="radio"/> 3. Probably benign (Category 3) <input type="radio"/> 4. Suspicious (Category 4) <input type="radio"/> 5. Highly suggestive of malignancy (Category 5) <input type="radio"/> 6. Known malignancy (Category 6) <input type="radio"/> 7. Incomplete—Need additional imaging evaluation (Category 0)	12c. MRI paid by <input type="radio"/> 1. BCCEDP <input type="radio"/> 2. Other <input type="radio"/> 3. Unknown <input type="radio"/> 4. BCCEDP / Insurance <input type="radio"/> 5. Insurance Only
13. Pap Test <input type="radio"/> 1. Performed; routine pap test → <input type="radio"/> 2. Performed; patient under surveillance for previous abnormal test → <input type="radio"/> 3. Performed, not paid by BCC; patient referred for DX Evaluation: DX referral date: ____/____/_____ <input type="radio"/> 4. Performed Pap after primary HPV+ → <input type="radio"/> 5. Not performed <input type="radio"/> 6. Refused	13a. Pap Test Date ____/____/_____ (mm / dd / yyyy)	13b. Pap Test Result <input type="radio"/> 1. Negative <input type="radio"/> 2. ASC-US <input type="radio"/> 3. Low grade SIL (including HPV changes) <input type="radio"/> *4. ASC-H <input type="radio"/> *5. High grade SIL <input type="radio"/> *6. Squamous cell carcinoma <input type="radio"/> *7. Atypical glandular cells <input type="radio"/> *8. Adenocarcinoma in situ* <input type="radio"/> *9. Adenocarcinoma <input type="radio"/> 10. Other _____ <input type="radio"/> 11. Unsatisfactory	13c. Pap paid by <input type="radio"/> 1. BCCEDP <input type="radio"/> 2. Other <input type="radio"/> 3. Unknown <input type="radio"/> 4. BCCEDP / Insurance <input type="radio"/> 5. Insurance Only
14. HPV Test <input type="radio"/> 1. Co-Test or Screening → <input type="radio"/> 2. Reflex → <input type="radio"/> 3. Not performed <input type="radio"/> 4. Refused	14a. HPV Test Date ____/____/_____ (mm / dd / yyyy)	14b. HPV Test Result <input type="radio"/> 1. Positive with genotyping not done/unknown <input type="radio"/> 2. Negative <input type="radio"/> *3. Positive with positive genotyping (types 16 or 18) <input type="radio"/> 4. Positive with negative genotyping (positive HPV, but not types 16 or 18) <input type="radio"/> 5. Unknown	14c. HPV paid by <input type="radio"/> 1. BCCEDP <input type="radio"/> 2. Other <input type="radio"/> 3. Unknown <input type="radio"/> 4. BCCEDP / Insurance <input type="radio"/> 5. Insurance Only

* Immediate Diagnostic Testing Indicated

Client Identification



Program # _____ Last name _____ Visit Date ____/____/____
(mm / dd / yyyy)

ID # _____ First Name _____ Middle Initial _____

Follow-up Plan

15. Breast diagnostic workup planned? 1. Yes 2. No
16. Breast short-term (less than 9 months) visit recommended? 1. Yes 2. No
 ↳ 1. Yes 2. No → 16a. Breast short-term visit date: ____/____/____ (mm/yyyy)
17. Cervical diagnostic workup planned? 1. Yes 2. No
18. Cervical short-term (less than 9 months) visit recommended? 1. Yes 2. No
 ↳ 1. Yes 2. No → 18a. Cervical short-term visit date: ____/____/____ (mm/yyyy)
19. **Alert** Blood Pressure workup planned? 1. Yes 2. No 3. Follow-up—workup by alternate provider 4. Refused
20. **Abnormal** Blood Pressure follow-up recommended? 1. Yes 2. No
 ↳ 1. Yes 2. No → 20a. Abnormal follow-up date: ____/____/____ (mm/yyyy)