

<p><b>Comments:</b></p>	<p style="text-align: center;">- Affix label here-</p> <p>Clinical Center/ID: _____ - _____ - _____</p> <p>First Name _____ M.I. _____</p> <p>Last Name _____</p>
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1. Contact date: \_\_\_\_\_ (M/D/Y)
2. Completed by: \_\_\_\_\_
3. Contact type:
- <sub>1</sub> Phone      <sub>3</sub> Visit
- <sub>2</sub> Mail      <sub>8</sub> Other

4. Visit type:
- <sub>1</sub> Screening # \_\_\_\_\_
- <sub>2</sub> Semi-Annual # \_\_\_\_\_
- <sub>3</sub> Annual # \_\_\_\_\_
- <sub>4</sub> Non-Routine

5. Date pelvic exam performed: \_\_\_\_\_ (M/D/Y)

6. Pelvic exam performed by:
- <sub>1</sub> CC staff
- <sub>2</sub> Other

6.1. Report taken by: \_\_\_\_\_

6.2. MD Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

6.3. Were there any abnormal findings found during the pelvic exam?

<sub>0</sub> No

<sub>1</sub> Yes

6.4. Verbal report provided by:

\_\_\_\_ Clinician:  
Name/Title \_\_\_\_\_

\_\_\_\_ Participant

- |                             | No                                    | Yes,<br>probably<br>benign            | Yes,<br>possibly<br>malignant         |
|-----------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 8.1. Atrophy                | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 8.2. Smooth                 | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 8.3. Pale                   | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 8.4. Friable with contact   | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 8.5. Blood present          | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 8.6. Abnormal discoloration | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 8.7. Ulceration             | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 8.8. Growth                 | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |

- 8.9. Cystocele:
- <sub>0</sub> None
- <sub>1</sub> Grade 1 (in vagina)
- <sub>2</sub> Grade 2 (to introitus)
- <sub>3</sub> Grade 3 (outside vagina)

- 8.10. Rectocele:
- <sub>0</sub> None
- <sub>1</sub> Grade 1 (in vagina)
- <sub>2</sub> Grade 2 (to introitus)
- <sub>3</sub> Grade 3 (outside vagina)

Chart notes:

7. External genitalia (vulva):
- |                             | No                                    | Yes,<br>probably<br>benign            | Yes,<br>possibly<br>malignant         |
|-----------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 7.1. Loss of adipose tissue | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 7.2. Thinning of hair       | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 7.3. Abnormal discoloration | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 7.4. Ulceration             | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |
| 7.5. Growth                 | <input type="checkbox"/> <sub>0</sub> | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> |

9. Cervix:

- <sub>0</sub> Absent
- <sub>1</sub> Present

	No	Yes, probably benign	Yes, possibly malignant
9.1. Flush with vaginal vault	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
9.2. Friable with contact	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
9.3. Surface lesion/growth (other than ectopy, Nabothian cyst)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
9.4. Polyp	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

10. Uterus:

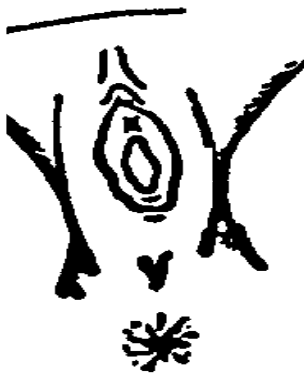
- <sub>0</sub> Absent (Go to Question 11.)
- <sub>1</sub> Present
- <sub>9</sub> Unable to palpate (Go to Question 11.)

	10.2. Uterine size:	10.3. Enlarged since last exam:
10.1. Prolapse:		
<input type="checkbox"/> <sub>0</sub> None	<input type="text"/> weeks	<input type="checkbox"/> <sub>0</sub> No
<input type="checkbox"/> <sub>1</sub> Grade 1 (in vagina)		<input type="checkbox"/> <sub>1</sub> Yes
<input type="checkbox"/> <sub>2</sub> Grade 2 (to introitus)		
<input type="checkbox"/> <sub>3</sub> Grade 3 (outside vagina)		

11. Adnexae:

- <sub>0</sub> Normal
  - <sub>1</sub> Mass present
  - <sub>9</sub> Unable to palpate/absent
- |       |   |
|-------|---|
| 11.1. | <input type="checkbox"/> <sub>1</sub> Right |
|       | <input type="checkbox"/> <sub>2</sub> Left  |
|       | <input type="checkbox"/> <sub>3</sub> Both  |

External genitalia:



PAP SMEAR

12. Was Pap smear obtained?

- <sub>0</sub> No, not done
- <sub>1</sub> No, send for outside report
- <sub>2</sub> Yes, vaginal smear
- <sub>3</sub> Yes, Pap smear

Initiate Form 92 - Pap Smear

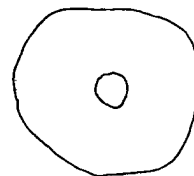
Follow-up

13. Was a referral made for follow-up care?

- <sub>0</sub> No
- <sub>1</sub> Yes

13.1. Referred by: <input type="text"/>
13.2. Date of referral: <input type="text"/> (M/D/Y)
13.3. Referred to:
MD/Clinic: <input type="text"/>
Address: <input type="text"/>
Phone: <input type="text"/>
13.4. Pelvic follow-up results:
<input type="checkbox"/> <sub>0</sub> Normal
<input type="checkbox"/> <sub>1</sub> Benign changes
<input type="checkbox"/> <sub>2</sub> Possibly malignant

Cervix/vagina:



Ovaries/uterus:

