Cervical Cancer Screening Program
Pap Smear Questionnaire

For Office & Lab Use Only

Please fax results to
Dr._____
at_____

Please ensure **ALL** sections of this form are filled out, including **TODAY'S DATE**.

Today's Date:		
General Information		
Name: (First) Middle: Last:		
Date of Birth: DD/MM/YY	Age:	Doctor's Name:
P.O. Box	Island:	Postal Code:
Street Address:		
Phone Home:	Phone Work:	Cell
Fax:	Email	
Health Insurance Provider & Type:		

Medical Questionnaire		
Do you have regular monthly periods? If YES when did your last period begin?	YES	NO
Has your doctor told you that you have gone through menopause?	YES	NO
Have you had a hysterectomy? If **YES**, date __/__/__/ DD/MM/YY	YES	NO
Do you have any abnormal vaginal bleeding e.g. between your periods, after sex or after menopause? If YES please explain:	YES	NO
Have you noticed any recent changes in your periods? If YES please explain:	YES	NO
Do you have any unusual vaginal discharge?	YES	NO
Do you have any vaginal itching?	YES	NO
Do you have any pelvic pain?	YES	NO
Have you ever been pregnant? If YES how many children do you have?	YES	NO
Have you ever used oral contraceptives (the pill) If YES for how long?	YES	NO
Have you ever had a Pap smear? If YES when was your last Pap smear?	YES	NO
Have you ever had an abnormal Pap smear? If YES, please explain	YES	NO
Has a doctor ever told you that you have any type of cancer? If Yes what type of cancer?	YES	NO
Has your mother or father, or sister or brother, or daughter or son ever had cancer? If YES who had cancer? What type of cancer?	YES	NO
Do you smoke?	YES	NO

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Medical Information Release Form

I, _____, give permission to Dr_____ and staff of the lab to share information on my pap screening results with the Cayman Islands Medical Directors and staff of CICS.

Signature:_____ Date:_____

PATIENT INFORMATION

Name: _____

Address: _____

Phone:_____ Date of Birth:_____