(See DD Form 2005 for Privacy Act Statement)

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

PAP FLOWSHEET

OTSG APPROVED *(Date)*

Patient: Please complete all blocks that have shaded titles.

1. Age:	2. Race:	3. Occupation:	4. Marital status:	5a. Last menstrual period:	5b. Cycle:	5c. Duration:

5d. Was it regular?	6. GPAL Data:	7. Contraception:	8. Plans for Pregnancy:
☐ Yes ☐ No	G ____ P ____ A ____ L ____		

9. Date of Last Pap:	10. Any Abnl?	11. Date of Last Mammogram:	12. Immunizations:	13a. Date of Last Cholesterol Test:
☐ Normal ☐ Abnormal	☐ Yes ☐ No	☐ Normal ☐ Abnormal	☐ dT ☐ Flu ☐ Pneumonia	

13b. Results of last cholesterol:	14a. Do you do a regular self breast exam?	14b. Frequency of self breast exams: *(Leave blank if answer to 14a was "No".)*
HDL _____ TG _____ Total _____ LDL _____	☐ Yes ☐ No	

15. Surgeries:

16. Medications:

17. Hormone Therapy?	18. Allergies *(specify medication and reaction)*:

19a. Past medical history:

Self	Your family	Self	Your family	Self	Your family	Self	Your family
☐	☐ Weight loss/gain	☐	☐ Breast disease	☐	☐ Kidney disease	☐	☐ Diabetes
☐	☐ Headaches	☐	☐ Jaundice/Hepatitis	☐	☐ Urinary problems	☐	☐ Cancer
☐	☐ Heart attack/Chest pain	☐	☐ Gall bladder disease	☐	☐ Anemia/Blood disease	☐	☐ Epilepsy
☐	☐ High blood pressure	☐	☐ Stomach ulcers	☐	☐ Varicose veins/Phlebitis	☐	☐ Arthritis/Osteoporosis
☐	☐ Lung disease	☐	☐ Bowel disorders	☐	☐ Thyroid disease	☐	☐ Tuberculosis

19b. Comments concerning personal and/or family past medical history:

_____

_____

_____

_____

20. Habits:

Tobacco: _____ Alcohol: _____ Caffeine: _____ Regular exercise: ☐ Yes ☐ No

21a. Please rate your current level of pain on the following scale. *(Circle the applicable number.)*	0 1 2 3 4 5 6 7 8 9 10	21b. If you are experiencing pain, where?

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

22. Chief complaint:

_____

_____

_____

_____

23. Physical examination:

a. Vitals: BP _____ T _____ P _____ RR _____ WT _____

b. Thyroid: ☐ Normal _____

c. Breast: ☐ Normal _____

d. Lymph: ☐ Normal _____

e. Vulva: ☐ Normal _____

f. BUS: ☐ Normal _____

g. Cervix: ☐ Normal _____

h. Uterus: ☐ Normal _____

i. Adnexa: ☐ Normal _____

j. Rectal: ☐ Normal _____

k. Vag: ☐ Normal _____

l. Guaiac: ☐ Positive ☐ Negative

m. KOH/Wet prep: _____

n. Other pertinent physical exam:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

24. Assessment/Plan:

_____

_____

_____

_____

25. Preventive Medicine:

(1) Pap: ☐ Done ☐ Follow up by mail

(2) Contraception: _____

(3) Immunizations: _____

(4) Cholesterol: _____

(5) Flex Sig: _____

(6) Mammogram: _____

(7) Hormone therapy: _____

(8) Breast self exam: ☐ Encouraged monthly self-exam.

(9) Calcium: _____

(10) Other PM: _____

(11) Follow up: ☐ Return in 1 year or as needed: _____

☐ The patient is educated and understands and agrees to the plan of care.

Signature: _____