

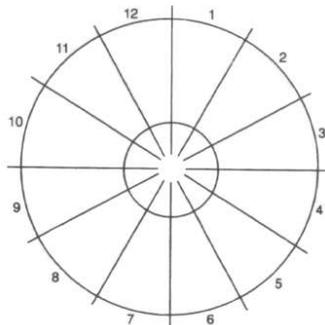
MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE COLPOSCOPIC EXAMINATION - INITIAL	OTSG APPROVED (Date)
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MARITAL STATUS: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep		PHONE NO: Home ()		Work ()	
REFERRED BY:			PHONE: ()		
G	P	AB	M	LAST PREGNANCY	LMP
COITARCHE		BIRTH CONTROL HISTORY			
VIRAL - HPV		HERPES	DES	FAMILY HISTORY	
SMOKING					
MEDICATIONS					
LAST PAP TEST (DATE)		CYTOLOGY		PREV. PAP TEST (DATE)	
CYTOLOGY					
PREVIOUS BIOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO					
PREVIOUS THERAPY:					
REASON FOR STUDY					

EXAMINATION	VULVA	CERVIX
TRANSFORMATION ZONE: <input type="checkbox"/> FULLY VISUALIZED <input type="checkbox"/> NOT FULLY VISUALIZED <input type="checkbox"/> UNSATISFACTORY <input type="checkbox"/> BIOPSY		
TRANSFORMATION ZONE		CHANGES
WITHIN	OUTSIDE	MINOR MAJOR
<input type="checkbox"/>	<input type="checkbox"/>	ACETOWHITE EPITH (AW) <input type="checkbox"/> <input type="checkbox"/>
		a) flat
		b) micropapillary
<input type="checkbox"/>	<input type="checkbox"/>	PUNCTATION (PU) <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	MOSAIC (MO) <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	LEUKOPLAKIA (LE) <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	IODINE - NEG EPITH (I-E) <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	ATYPICAL VESSELS (AV) <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	EROSION (ER) <input type="checkbox"/> <input type="checkbox"/>
MISC. FINDINGS - <input type="checkbox"/> NON-ACETOWHITE MICROPAP SURFACE <input type="checkbox"/> EXOPHYTIC CONDYLOMA <input type="checkbox"/> INFLAM <input type="checkbox"/> ULCER		



(SITE) -
 PICTURES

COLPOSCOPIC DX -	
DISPOSITION	COMMENTS
<input type="checkbox"/> REPEAT CYTOLOGY	
<input type="checkbox"/> REPEAT COLPOSCOPY	
<input type="checkbox"/> ELECTRO CAUTERY	
<input type="checkbox"/> CRYOSURGERY	
<input type="checkbox"/> LASER	
<input type="checkbox"/> LEEP	
<input type="checkbox"/> CONE	
<input type="checkbox"/> HYSTERECTOMY	

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)	<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT
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