

**MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA**

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

<b>REPORT TITLE</b> <b>COLPOSCOPIC EXAMINATION - FOLLOW UP</b>	<b>OTSG APPROVED (Date)</b>
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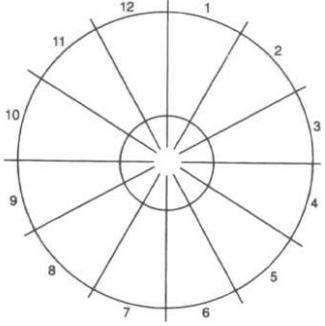
LAST PAP TEST (DATE)	CYTOLOGY	PREV. PAP TEST (DATE)	CYTOLOGY
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PREVIOUS BIOPSY?  YES  NO    PREVIOUS THERAPY:

**FOLLOW UP VISIT**     1ST     2D     3D

<b>EXAMINATION</b>	VULVA	CERVIX
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TRANSFORMATION ZONE:  FULLY VISUALIZED     NOT FULLY VISUALIZED     UNSATISFACTORY     BIOPSY

<u>TRANSFORMATION ZONE</u>		<u>CHANGES</u>		
WITHIN	OUTSIDE	MINOR	MAJOR	
<input type="checkbox"/>	<input type="checkbox"/>	ACETOWHITE EPITH (AW)	<input type="checkbox"/>	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> a) flat  <input type="checkbox"/> b) micropapillary </div> <div style="width: 30%; text-align: center;">  </div> </div>
<input type="checkbox"/>	<input type="checkbox"/>	PUNCTATION (PU)	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	MOSAIC (MO)	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	LEUKOPLAKIA (LE)	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	IODINE - NEG EPITH (I-E)	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	ATYPICAL VESSELS (AV)	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	EROSION (ER)	<input type="checkbox"/>	(SITE) -  <input type="checkbox"/> PICTURES

MISC. FINDINGS -  NON-ACETOWHITE MICROPAP SURFACE     EXOPHYTIC CONDYLOMA     INFLAM     ULCER

**COLPOSCOPIC DX -**

<b>DISPOSITION</b>	<b>COMMENTS</b>
<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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