

FAMILY PLANNING COLPOSCOPY RECORD

Name _____

Age _____ Date of Birth _____

Allergies _____

G ___ T ___ P ___ A ___ L ___ LNMP _____ UCG _____

Current Method of Contraception _____

Current Medications (prescription, OTC, vitamins, herbal) _____

Initial colposcopy visit Follow-up colposcopy visit

Reason(s) for Visit _____

Pertinent past GYN history, medical history, history of abnormal Pap(s) and/or HPV test(s), colposcopy, related treatment and/or procedures _____

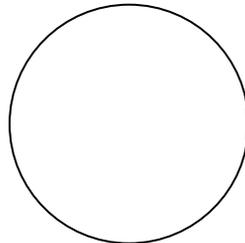
Date _____ Interpreter Signature _____

Date _____ Staff Signature _____

Colposcopy Findings:

Satisfactory yes no Pap HPV CT GC HSV Biopsy(s) ECC

Wet Mount _____



Assessment _____

Plan(s) after Colposcopy _____

Date _____ Chaperone Signature _____

Interpreter Signature _____ Colposcopist Signature _____

Summary of laboratory reports from this evaluation _____

Plan after reports _____

Date _____ Staff Signature _____

Interpreter Signature _____ Colposcopist Signature _____