HUS Diagnostic Center

MEDICAL HISTORY FORM FOR CERVICAL CANCER SCREENING

First names	Last name	Personal identity code
Address		

Medical history

First day of last menstrual period (date)

Menstruation have stopped permanently (menopause)
☐ No ☐ Yes

Pregnant
☐ No ☐ Yes

Present birth control method
☐ No birth control method ☐ Hormonal IUD
☐ Birth control pill ☐ Other hormonal birth control
☐ IUD

Less than six months after giving birth or breastfeeding
☐ No ☐ Yes

Hormone replacement therapy
☐ No ☐ Yes

Symptoms
☐ No symptoms ☐ Irregular bleeding between periods
☐ Abnormal / bloody vaginal discharge ☐ Bleeding though periods have stopped at least a year ago
☐ Bleeding during / after intercourse

Hysterectomy
☐ No ☐ Yes

If yes, was the hysterectomy
☐ Partial ☐ Total

Have you had cervical cell samples taken previously
☐ No ☐ Yes

If yes, have you had samples taken withing the past two years
☐ No ☐ Yes

If yes, what was the result of the last cervical cell sample
☐ Normal
☐ Abnormal
☐ Do not know

Have you been treated due to cervical cell changes
☐ No ☐ Yes

If yes, when was the last time (year)