CERVICAL CANCER

SCREENING FORM

PERSONAL INFORMATION

Full Name :

Age :

Date of Birth : D D M M Y Y

E-Mail :

Phone Number :

PAP SMEAR AND HPV VACCINATION

Last Pap smear date:

HPV vaccination status:

SEXUAL HISTORY

Number of sexual partners:

History of sexually transmitted infections (STIs):

Family history of cervical cancer:

History of hysterectomy :

THANK YOU FOR YOUR INFORMATION