Pap Consent Form

Date: _____________

I, ___________________________, hereby give consent to having my pap smear and associated swabs and services provided by the:

___Registered Nurse
___Midwifery Student
___International Medical Graduate (Unlicensed Physician)
___Nurse Practitioner Student
___Medical Resident

who is working for the responsible physician in a delegation capacity in order to develop relevant practice experience in the office/clinic environment.

I understand that the above person is working under the supervision of Dr. _________________________, who may or may not need to repeat any or all aspects of my services as necessary.

X______________________________	**X__________________**
Patient	**Student/IMG/RN**

Pap Clinic History **Rostered** ☐

Patient Label

Are you sexually active ☐Yes ☐No
When was your last pap test___________________________________

First day of your last menstral period_____________________________
Is it possible that you are pregnant ☐Yes ☐No
HCG **☐Positive ☐Negative**
Are you planning to be pregnant in the next year ☐Yes ☐No

Have you had any of the following problems in the past 3 months:
Abnormally heavy periods (ie. That make you light headed or feel weak/tired) ☐Yes ☐No
Bleeding after intercourse ☐Yes ☐No
Bleeding between your periods ☐Yes ☐No
Post menopausal bleeding [if applicable] ☐Yes ☐No
Pelvic pain or pain with intercourse ☐Yes ☐No

Do you have discharge every day of the month ☐Yes ☐No
Is it itchy ☐Yes ☐No
Does it smell ☐Yes ☐No

If you have recently had a baby
How many weeks since bthe delivery (postpartum)_____________________

How many pregnancies have you had G____________
Have many children have you delivered P___________
How many abortions/miscarriages have you had________

If you have you gone through menopause/are you going through menopause
Do you use hormone replacement therapy ☐Yes ☐No
If yes, please specify which ones: _________________________________
____

Do you have an IUCD ☐Yes ☐No
If yes, please specify which type: ☐Mirena ☐Copper

Do you use birth control pills ☐Yes ☐No
If yes, please answer questions below:
Please specify which type: ______________________________
Do you need you birth control pills renewed ☐Yes ☐No
Do you smoke ☐Yes ☐No
Do you have a history of the following:
Hypertension ☐Yes ☐No
Bloodclots ☐Yes ☐No
Migraine ☐Yes ☐No
Renal Disease ☐Yes ☐No
Liver Disease ☐Yes ☐No
Side effects from current birth control pill ☐Yes ☐No
____

Sexually Transmitted Disease:
Have you ever had any of the following problems:
a. Chlamydia ☐Yes ☐No
b. Gonorrhea ☐Yes ☐No
c. HPV (warts) ☐Yes ☐No
d. Herpes Simplex Virus ☐Yes ☐No
e. HIV ☐Yes ☐No
Other__________________________

Have you been vaccinated against HPV (prevents genital warts and cervical cancer) ☐Yes ☐No

Have you had a hysterectomy ☐Yes ☐No
☐Subtotal (Cervix left in)
☐Total (Cervix taken out)
Do you still have ovaries ☐Yes ☐No

Have you ever had any of the following problems or procedures:
Abnormal pap smears ☐Yes ☐No
If yes, Date:____________________________________
Problem:_____________________________________
Previous colposcopy or cervix biopsy ☐Yes ☐No
If yes, Date:____________________________________
Result:_______________________________________
Laser treatment of cervix ☐Yes ☐No
Previous Irradiation for cervical cancer ☐Yes ☐No
Cryotherapy for warts or cancer ☐Yes ☐No
Chemotherapy ☐Yes ☐No
If yes to any of the above, have you had normal pap results since then? ☐Yes ☐No

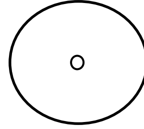
Do you have any pap related or gynaecological concerns?
____
____
____

Thank you for your assistance.

Staff Use Only

External genitalia: Normal Abnormal ____________________________________

Cervix: Normal Abnormal Erosion



Uterus: Soft and non-tender ☐Yes ☐No

Enlarged ☐Yes ☐No

Fibroids ☐Yes ☐No

Tender ☐Yes ☐No

Other____

Adnexal tenderness and mass ☐Yes ☐No