Patient Information (Please Print)

Patient Name _____
Patient I.D.# _____
Age / DOB _____

Physician Name _____
Physician Telephone (___)____-_____

CYTOLOGY, INC.

1301 YOUNG STREET, ROOM 833
DALLAS, TEXAS 75202

Dr. Ding L. Berry, MD, PA

Collection

Date_____

Time _____

#Slides_____

Specimen Source

Cervical _____
Endocervical _____
Endocervical Aspiration _____
Endometrial Aspiration _____
Vaginal _____
OTHER_____

Previous Pap

Date _____

Results _ _____

LMP _____

Clinical Information
(CHECK ALL THAT APPLY)

Pregnant
Cauterization
Post Partum
Cryosurgery
Post Abortion
Laser Surgery
Menopause
Hysterectomy
IUD
Abnormal bleeding
DES
Carcinoma
Oral Contraceptives
Chemotherapy
Exogenous Hormone
Radiation

Additional Clinical Information:

_____
_____
_____
_____
_____
_____
_____