

Florida Women's Health Center

Name: _____

Date: _____

WELL WOMAN EXAM - MEDICARE PATIENTS

What Medicare covers:

Medicare covers 1 Pap test and pelvic exam every 2 years for women who are at low risk for cervical cancer. A clinical breast exam is included as part of the pelvic screening benefit. The beneficiary pays a 20% copayment or coinsurance for the Pap test collection and pelvic and breast exams, but does not have to meet the yearly Part B deductible. The beneficiary pays nothing for the Pap laboratory test.

Medicare covers 1 Pap test and pelvic exam every year for women who:

- Are of childbearing age and who have had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years;
- Are considered high risk (as described previously) for developing cervical or vaginal cancer.

Checking yes to one or more of these boxes puts you in the high risk category.

Please check (✓) if you have ever been treated for any of the following infections:

Vaginosis	<input type="checkbox"/>	Genital Warts	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>
Trichomonas	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>

		<u>Yes</u>		<u>No</u>	
Have you missed your Pap smears for 7 consecutive years?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Have you <u>ever</u> had an abnormal Pap smear test?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	If so, when? _____
Did you begin sexual activity before you were 16 years old?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Have you had more than 5 sexual partners in your lifetime?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Have you ever tested positive for the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Did your mother take the drug DES when she was pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Patient Signature: _____

Date: _____

 Julie Schneider, MD (Physician Signature)