MEDICAL EXAMINATION RECORD

Initial | Annual | 6 mo. | Age | Date of Visit | Patient Name

COUNSELING EDUCATION

CHECK COUNSELING/EDUCATION PROVIDED:

- Breast cancer education ☐
- Cervical cancer education ☐
- Colorectal cancer education ☐
- Smoking cessation education ☐
- Menopause ☐
- Other (Specify): ☐

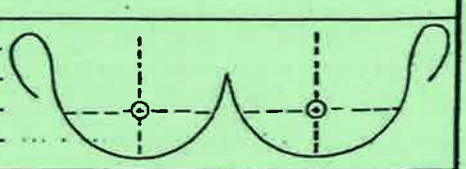
	YES	NO
Has patient demonstrated understanding of education?	☐	☐
Is follow-up counseling/education necessary?	☐	☐

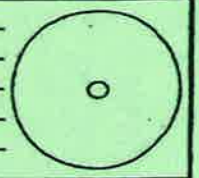
Patient's Choice of Method:

Notes:

Counselor Signature:

PHYSICAL EXAMINATION	Normal (✓)	Ab-Normal (✓)	Comments and Additional Data
Weight (Abnormal if appears obese)			Specify wt.:
Height			Specify ht.:
Blood Pressure			Specify BP:
Skin/Hair Distribution			
Breasts			
Cardiorespiratory (in detail if indicated)			
Thyroid			
Abdomen			
Extremities			
Neurologic (in detail if indicated)			
External Genitalia			Discharge
Vagina			
Cervix			
Uterus: Size/Shape			Position
Adnexae			
Rectovaginal			
Other physical findings (specify):			





LABORATORY	Ordered/ Provided (✓)	Normal (✓)	Ab-Normal (✓)	Results and Dates (if not current)	Date of Result mo.	day	yr.
Hct or High							
Urine Chemistry				Protein Sugar			
Vaginal Smear							
Pap Smear					mo.	day	yr.
Hemoccult					mo.	day	yr.
Other (Specify):					mo.	day	yr.

PLAN

Brand (dose, size, lot #, etc.)

Special instructions/comments

FDA Labeling Provided: ☐ Yes ☐ No

Treatment/Referrals: (list all medications given or prescribed and referrals made):

Return interval to family planning:	Next Appointment:	Clinician Signature:

CLINIC NOTES

GYNECOLOGICAL/MENSTRUAL HISTORY

a. Date and result of last pap smear _____ / _____ / _____ Normal ☐ Abnormal ☐

b. Date and result of last pelvic exam _____ / _____ / _____ Normal ☐ Abnormal ☐

c. Date and result of last mammogram _____ / _____ / _____ Normal ☐ Abnormal ☐

d. First day of last or current period _____ / _____ / _____

e. Age period began _____ f. Age period stopped _____

g. Age at first intercourse: _____ Before age 18 _____ After age 18

h. Total number of days you flow _____

i. Amount of flow: Heavy _____ Medium _____ Light _____

j. Number of days between period (first day to first day) _____

k. Number of sexual partners: _____ 0-5 _____ 6+

	YES	NO
l. Do you examine your breasts?		
m. Are you currently having sexual intercourse?		
n. Have you had previous abnormal pap smears?		
o. Are your periods regular?		
p. Do you have cramps or pain with your period?		
q. Have you missed a period within the last 6 months?		
r. Do you have abnormal bleeding?		
s. Do you have any unusual vaginal discharge?		
t. Do you have pain or bleeding during or after sex?		
u. Do you douche?		

CLINIC NOTES

Reason for Visit: _____

Clinic Staff Signature _____ Date _____/_____/_____

PATIENT SIGNATURE

_____

_____ Date _____/_____/_____