

FEMALE MEDICAL EXAM

Name \_\_\_\_\_ Age \_\_\_\_\_

Date \_\_\_\_\_

ALLERGIES \_\_\_\_\_  NKDA

**SUBJECTIVE**  
 Chief complaint/Purpose of visit: \_\_\_\_\_  
 \_\_\_\_\_  
 G \_\_\_\_\_ P \_\_\_\_\_ TAB \_\_\_\_\_ SAB \_\_\_\_\_ Ectopic \_\_\_\_\_ LMP \_\_\_\_\_ LNMP \_\_\_\_\_  
 Current BCM \_\_\_\_\_ Since \_\_\_\_\_ Date of last pill/injection \_\_\_\_\_  
 Currently breast feeding?  Yes  No  
 BCM desired \_\_\_\_\_  
 Last unprotected intercourse (UPIC) \_\_\_\_\_ EC used? \_\_\_\_\_  
 STD risk factors (past 12 months or since last visit/risk assessment):  None  Not assessed  
 Known/suspected exposure  Inconsistent condom use (<100%)  
 New or >1 partner  Personal/partner IDU  
 Possible non-monogamous partner  Hx of STD diagnosis  
 Staff signature: \_\_\_\_\_ Title: \_\_\_\_\_ Time: \_\_\_\_\_  
 Present history: \_\_\_\_\_  
 \_\_\_\_\_

**OFFICE TESTS**  
 Pregnancy Test  
 Positive  
 Negative  
 Urinalysis  
 Leukocytes  
 Nitrites  
 Protein  
 Glucose  
 Wet Mount  
 Candida  
 Trich  
 Clue Cells  
 WBCs: \_\_\_\_\_  
 Vaginal pH: \_\_\_\_\_ Amine + -  
**LAB TESTS**  
 Pap  Ct  
 GC  HIV  
 Syphilis  Glucose  
 GTT  Cholesterol  
 Lipids  LFTs  
 Urine C/S  CBC  
 Herpes  Mammo  
 Other lab tests: \_\_\_\_\_  
 \_\_\_\_\_

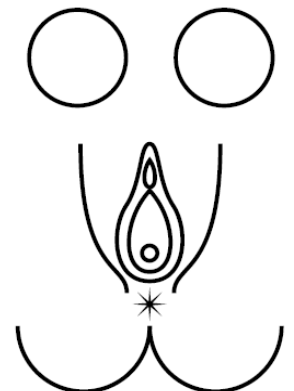
**OBJECTIVE**  
 Vital signs: WT \_\_\_\_\_ HT \_\_\_\_\_ BMI \_\_\_\_\_ BP \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_  

PHYSICAL EXAM	NL	ABN	Not Done	Description
Neck/Thyroid				
Heart				
Lungs				
Breast <input type="checkbox"/> BSE reviewed				
Abdomen				
GYN: Ext. genitalia				
Urethral meatus				
Urethral/bladder				
Vagina				
Cervix				
Uterus				
Adnexae				
Anus/perineum				

 Other: \_\_\_\_\_  
 Physical exam not performed:  Not indicated \_\_\_\_\_  Patient declines \_\_\_\_\_  
 Done elsewhere \_\_\_\_\_  Records request \_\_\_\_\_

**EDUCATION**  
 Contraceptive options  
 Method: \_\_\_\_\_  
 Warning signs/risks  
 Side effects  
 Usage  
 Emergency contraception (EC)  
 Condoms/spermicides  
 Safer sex/STI  
 Alcohol/drug use  
 Preconception planning  
 Parental involvement (if <18)  
 Mammogram (if >40)

**MEDICAL DECISION MAKING**  
 Assessment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Plan:  BCM \_\_\_\_\_  
 \_\_\_\_\_  
 Referral/  Consultation \_\_\_\_\_  RTC \_\_\_\_\_ /PRN  
 Rx dispensed \_\_\_\_\_  
 >50% of visit was counseling/coordination of care. Clinician time: \_\_\_\_\_



Clinician signature: \_\_\_\_\_  
 Print name: \_\_\_\_\_ Date/time: \_\_\_\_\_

