

Physical Exam

PLACE PATIENT LABEL HERE

Patient ID # _____

DATE OF EXAM ____ / ____ / ____

- New Pt. Well-Woman Exam
 New Pt. Problem
 Est. Pt. Well-Woman Exam
 Est. Pt. Problem

NAME	
AGE	DOB
LMP	
Current MEDS	
Current BCM	
ALLERGIES	
PFSH of ____/____/____ Reviewed <input type="checkbox"/> No changes <input type="checkbox"/> Updated	
STI RISKS: Change in partner since last exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are both pt and partner mutually monogamous? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current partner's STI status: <input type="checkbox"/> HSV <input type="checkbox"/> HBV <input type="checkbox"/> HCV <input type="checkbox"/> Unknown	
Partners: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both	
<input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Anal Sex	
With partner _____ wks / mos / yrs	
EDUCATION [if oral, if written]	
<input type="checkbox"/> Contraceptive options <input type="checkbox"/> Method education <input type="checkbox"/> Exam/lab findings discussed <input type="checkbox"/> Breast health <input type="checkbox"/> Problem education <input type="checkbox"/> UTI / Cystitis <input type="checkbox"/> Anemia / Iron / Diet <input type="checkbox"/> Cholesterol management <input type="checkbox"/> Infertility <input type="checkbox"/> Menopause <input type="checkbox"/> HT / ET <input type="checkbox"/> Parental involvement <input type="checkbox"/> Medications prescribed	<input type="checkbox"/> Initial PT education <input type="checkbox"/> Assessment / Plan discussed <input type="checkbox"/> STI / HIV education / Safer sex <input type="checkbox"/> Vaginitis / Vaginal infection <input type="checkbox"/> Partner treatment <input type="checkbox"/> Stop smoking <input type="checkbox"/> Weight control / Diet / Exercise <input type="checkbox"/> Options X 3 (Pregnancy) <input type="checkbox"/> Preconception / Folic Acid <input type="checkbox"/> Osteoporosis / Calcium <input type="checkbox"/> EC offered <input type="checkbox"/> Abstinence <input type="checkbox"/> HPV vaccine <input type="checkbox"/> Other _____
CLIENT INFORMATION (CI) PROVIDED	
CIICs* <input type="checkbox"/> The Pill <input type="checkbox"/> The Ring <input type="checkbox"/> The Patch <input type="checkbox"/> Special Considerations <input type="checkbox"/> HOPE <input type="checkbox"/> DMPA <input type="checkbox"/> EC <input type="checkbox"/> POPS <input type="checkbox"/> IUC <input type="checkbox"/> IUC with Special Conditions <input type="checkbox"/> IUC Use Beyond Recommendations <input type="checkbox"/> Misoprostol for GYN Procedures <input type="checkbox"/> Barriers <input type="checkbox"/> Implants <input type="checkbox"/> STI TX without an Exam	<input type="checkbox"/> Treatment of Genital Warts <input type="checkbox"/> Treatment of Bartholin's Duct Cyst or Abscess <input type="checkbox"/> PID <input type="checkbox"/> Endometrial Biopsy <input type="checkbox"/> Services Related to the Menopause CIs* <input type="checkbox"/> Herbal Medicine <input type="checkbox"/> Instructions for use of the Ring <input type="checkbox"/> Instructions for use of the Patch <input type="checkbox"/> Pregnancy with an IUC in Place <input type="checkbox"/> Condoms and Female Condoms <input type="checkbox"/> Spermicide for Birth Control <input type="checkbox"/> Directions for Chlamydia
CIs Provided in: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Treatment of Sex Partners <input type="checkbox"/> UTI <input type="checkbox"/> Pregnancy Testing, Evaluation & Options Services
*As of 2006 MS&Gs	

S: Reason for Visit / Chief Complaint / History of Present Illness	
VITAL SIGNS	
<input type="checkbox"/> BP _____ <input type="checkbox"/> Weight _____ <input type="checkbox"/> Height _____ <input type="checkbox"/> Temp _____	
O: Examination / Physical Findings	
SYSTEM	WNL
OTHER	
GENERAL	<input type="checkbox"/> No acute distress, grossly WNL
EYES	<input type="checkbox"/> Grossly WNL
ENMT	<input type="checkbox"/> Grossly WNL
CV	<input type="checkbox"/> RRR <input type="checkbox"/> Murmurs
RESP	<input type="checkbox"/> Clear to auscultation, equal breath sounds
GI	<input type="checkbox"/> Abdomen soft / non-tender, no masses <input type="checkbox"/> Liver / spleen non-palpable <input type="checkbox"/> Rectal exam (req. ≥ age 50) no masses / blood
GU	<input type="checkbox"/> Breasts w/no masses/discharge/tenderness <input type="checkbox"/> No urethral discharge <input type="checkbox"/> No CVAT <input type="checkbox"/> Vulva, no lesions, skin intact w/no discoloration <input type="checkbox"/> Vagina, normal color, no unusual discharge, no Bartholin enlargement / tenderness <input type="checkbox"/> Cervix, no lesions, no contact bleeding <input type="checkbox"/> Uterus, NS / NT / mobile / no CMT <input type="checkbox"/> AF <input type="checkbox"/> AV <input type="checkbox"/> RF <input type="checkbox"/> RV <input type="checkbox"/> Adnexa, non-tender w/no masses
MUSC.	<input type="checkbox"/> Back w/no curvature <input type="checkbox"/> Extremities full ROM
SKIN	<input type="checkbox"/> Intact w/no lesions <input type="checkbox"/> Piercing <input type="checkbox"/> Tattoo If yes, where? _____
ENDO	<input type="checkbox"/> Thyroid NS / NT / equal bilateral
LYMPH	<input type="checkbox"/> No lymphadenopathy neck / axilla /groin
LAB TESTS DONE	
<input type="checkbox"/> Hct _____ <input type="checkbox"/> Urine Dip (circle): Glucose Protein Nitrites Leukocytes <input type="checkbox"/> Pregnancy Test Pos Neg <input type="checkbox"/> Slide Pap <input type="checkbox"/> Liquid Based Pap <input type="checkbox"/> HSV <input type="checkbox"/> GC <input type="checkbox"/> CT <input type="checkbox"/> HPV <input type="checkbox"/> Other: _____ <input type="checkbox"/> Wet Mount: KOH Saline WNL + Clue/+ Whiff pH ____ +Hyphae +Trich WBC ____ hpf	
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Breast</p> <p>Right Left</p> </div> <div style="text-align: center;"> <p>Cervix</p> </div> </div>	

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ASSESSMENT

PLAN

Referral provided for _____ Referral to _____

- Explained nature and implication of abnormal findings.
- Explained consequences of not receiving additional care.
- Explained management option and referral.
- Explained responsibility to obtain follow-up care.

Client demonstrated understanding of education / findings / plan by

- Asking appropriate questions / returning
- Interpreter / Language Line. Provided by (name/relationship) _____
- Other _____

PRESCRIPTION

- DMPA 150 mg IM/Sq q 12 weeks x 5 Given today
- OCs _____ Sig: 1 qd X 1 yr # _____ today _____
- NuvaRing PV X 3 wks; out for 1 wk. X 1 yr # _____ today
- Ortho Evra 1 patch/wk X 3, none for 1 wk. X 1 yr # _____ today
- Start: Sunday p next menses Day _____ Today Continue
- IUD ParaGard Mirena Date Inserted: _____
- Implanon Date inserted _____
- Condoms # _____ requested by client for contraception/BUM STD prevention
- Other _____

- OK for emergency pack of pills if needed
- Advanced Rx EC x 1 year _____ today EC now: _____

INTERVIEWER _____ CLINICIAN _____

DATE _____