SCREENING RECORD
CHMPC
Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

Gynecological Exam

Date_____ Time _____
Actual Age_____ Weight _____lb _____ oz. Height _____in. BMI_____
Temp _____ Pulse _____ Resp _____ BP_____ Pain Score (0 – 5)_____
❑ Environmental Screen ❑ Growth chart plotted Nutrition: ❑ Vitamins ❑ Fluoride
Adverse Reactions (drug allergies): ❑ Yes* _____ ❑ No *If yes, also list on Patient Problem Summary in front of chart.
❑ Patient section reviewed? ❑ Patient's concerns addressed
❑ Immunizations current (copy in chart) ❑ Off Schedule ❑ Parental Refusal Explain _____
Current method of contraception: _____ Last mammogram: _____
Sexually Active Yes ____ No ____ Menarche age:_____ LMP_____ Gravida_____ Para _____
Last PAP:_____
Problems: _____

Current Medications: ❑None or list medications below.

Name	Dose	Frequency

Nurse's Signature
X

Physical: Check (☑) if normal. Circle if abnormal and describe.
Breast ❑ Normal ❑ Other
External Genitalia ❑ Normal ❑ Other
Urethral Meatus ❑ Normal ❑ Other
Urethra ❑ Normal ❑ Other
Bladder ❑ Normal ❑ Other
Vagina ❑ Normal ❑ Other
Cervix ❑ Normal ❑ Other
Uterus ❑ Normal ❑ Other
Adnexa ❑ Normal ❑ Other
Perineum/Anus ❑ Normal ❑ Other
Hymen ❑ Intact ❑ Open

Plan: ❑ HPV ❑ Flu ❑ Hgb (if necessary)_____Value ❑ Counseled
Patient Counseled: ❑ Weight Management/Exercise ❑ Contraception/Safe Sex ❑ Smoking Cessation ❑ Breast Self-Exam
If sexually active, ❑ Pap test, screen for: ❑ Chlamydia ❑ Gonorrhea
❑ Other _____

❑ Interpretive Conference Conducted Return _____
❑ Parent/guardian instructed to keep **Current Medication List** to share with other providers and for emergencies. **INITIALS**_____
❑ Parent/guardian verbalized understanding the **Plan of Care. INITIALS** _____

Physician/Practitioner's Signature **X**	**Date** / /	**Time** AM/PM :

SCREENING RECORD
CHMPC
Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

Patient Section
Gynecological Exam

SECTION TO BE COMPLETED BY PATIENT

Personal/Social History
Are you <u>CONCERNED</u> about…
(check appropriate box for each question)

	Yes	No
1. School/work: (circle) grades, motivation, concentration, completing assignments?	❑	❑
2. Your breasts, menses, pelvic pain, vaginal discharge?	❑	❑
3. Sexual issues: (circle) sexual orientation, sexually transmitted diseases, AIDS/HIV, other	❑	❑
4. Eating habits, weight loss, loss of energy, sleep habits?	❑	❑
5. Recurrent ear, sinus or throat infections, nosebleeds?	❑	❑
6. Chest pain, shortness of breath, or irregular heartbeat?	❑	❑
7. Frequent colds, cough, wheezing, recurrent bronchitis?	❑	❑
8. Abdominal pain, vomiting, diarrhea, constipation?	❑	❑
9. Urinary control, bed wetting, urinary infections?	❑	❑
10. Joint pain, stiffness, swelling, muscle pain, weakness?	❑	❑
11. Birthmarks, skin rashes, itching, nail or hair problems?	❑	❑
12. Recurrent headaches, dizziness, tics, weak, seizures?	❑	❑
13. Mood changes, sadness or nervous problems?	❑	❑
14. Excessive thirst or hunger, increased urination, weight loss?	❑	❑
15. Paleness, anemia, easy bruising, swollen glands?	❑	❑
16. Milk, food or drug allergies, recurrent infections?	❑	❑

Personal/Social

	Yes	No
17. Have you had a pelvic examination? approx. date _____ Pap test _____	❑	❑
18. When was your last menstrual cycle? _____		
19. Are you sexually active now?	❑	❑
If yes, do you always use a condom?	❑	❑
20. Do you use cigarettes, smokeless tobacco?	❑	❑
21. Do you drink alcohol?	❑	❑
If yes, do you drink: ❑ beer ❑ wine ❑ liquor ❑ rarely ❑ weekly ❑ daily # of drinks _____		
22. Have you been drunk in the past month?	❑	❑
23. Do you ever drive a vehicle when drinking?	❑	❑
24. Do you ever use recreational drugs?	❑	❑
25. Do you always use a seatbelt when in a car?	❑	❑
26. Are there guns in the house?	❑	❑

History Update

	Yes	No
27. Has there been a change in your medical history? _____	❑	❑
28. Has there been a change in your family medical history? _____	❑	❑
29. Has there been a change in your household situation? _____	❑	❑

Comments (Please Print)

	Yes	No
30. Do you have any concerns you wish to discuss?	❑	❑

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: