

McLaren Medical Group
GYNECOLOGICAL HISTORY & EXAMINATION

NURSING ASSESSMENT

DATE _____

AGE _____

VITALS: Height: Weight: B/P: T: P: R:

| | | | | | | |
|-----------------|------------------|--|--|--|--|--|
| Chief Complaint | | | | | | |
| | LMP | | | | | |
| | Signature: _____ | | | | | |

History of Present Illness: Questionnaire / ROS reviewed

EXAMINATION:

Vital Signs reviewed General Appearance _____

Orientation time place person

Mood/Affect normal depressed

anxious agitated

Neck: Neck/Thyroid

RESPIRATORY: WNL Y N

CARDIOVASCULAR: WNL Y N

BREASTS: Symmetrical Y N

Discharge Y N Lump/masses Y N

Nipples Everted Inverted

Other _____

GASTROINTESTINAL: Liver/spleen

Abdominal masses / tenderness Y N

Hernia Y N

Rectum /Anus WNL Y N **Hemoccult** Pos. Neg.

LYMPHATIC: Neck non-palpable

Axilla non-palpable Groin non-palpable

PELVIC: External genitalia

Urethra meatus WNL Y N

Urethra WNL Y N Cervix WNL Y N

Bladder WNL Y N Uterus WNL Y N

Vagina WNL Y N Adnexa WNL Y N

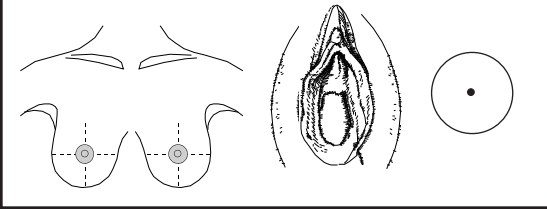
Date of Last:

Pap: Mamm: Bone Density:

NOTES/ASSESSMENT/PLAN:

P
H
Y
S
I
C
I
A
N
A
S
S
E
S
S
M
E
N
T

DIAGRAMS:



Time: _____ mins. 50% of time counseling

PATIENT NAME:

DATE OF BIRTH:

Signature of Provider _____

Date/Time _____