

Pelvic Exam

Patient information	
Name:	Date of birth:
Gender:	Date of assessment:
Medical history	
Menstrual history:	Sexual history:
Previous exams taken:	Known conditions:
Visual inspection	
Vulva:	
Vaginal opening:	
Notes and observations:	

Manual examination		
Uterus:		
Ovaries:		
Cervix:		
Notes and observations:		
Pap test (if applicable)		
Sample collected:	Yes	No
Date sent to lab:		
Additional tests ordered:		
Additional assessments		
Urinary symptoms:		
Bowel symptoms:		
Pelvic pain:	Yes	No

Other symptoms:

Additional notes

Healthcare professional information

Name:

License ID:

Signature:

Date of assessment: