The Arc
Prince George's County

GYNECOLOGICAL EXAMINATION RECORD

NAME:_____ DATE OF BIRTH:_____ AGE:_____

LMP:_____ Allergies:_____; None Known_____

Contraceptive Management: None_____ Yes_____ Type:

_____

Hysterectomy?_____ Tubal Ligation?_____

Last Mammogram Date: _____ Last Pap Smear Date: _____

Menstrual Pattern: Flow_____ Cycle_____ Menopause?_____

Today's concerns/problems: _____

_____

_____

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A GYNECOLOGICAL EXAM WAS PERFORMED ON THE ABOVE-NAMED PATIENT TODAY.

Pap Smear Done? Yes_____ No_____

Findings of Today's Examination:

_____

_____

_____

RECOMMENDATIONS – Please state recommended frequency for this patient for:

Gyn Exam_____ Pap smear_____ Mammogram_____

Other recommendations:_____

Examiner's Name (Printed): _____

Address: _____ Phone:_____

_____

_____ _____

Signature Date