EXAM FORM

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH – FAMILY PLANNING PROGRAM
SFN 8620 (5-2010)

Yes	No		STAFF COMMENTS
		1. Do you have any allergies (food, medications, latex)?	
		2. Are you currently taking any type of medication (prescription or over-the-counter)?	
		3. Are you currently taking any type of herbals, diet pills/supplements or vitamins?	
		4. Have you had surgery, emergency room or clinic visits since your last exam?	
		5. Have you had a blood transfusion or been exposed to any blood products since your last exam?	
		6. Has anyone in your family developed medical problems since your last exam?	
		7. Do you know how to do breast exams? How many do you do per year?	
		8. Have you noticed any breast concerns in the last year (tenderness, lumps, discharge, etc.)?	
		9. Do you use tobacco? ☐ smoke ☐ chew If yes, number of cans/cigarettes per day? _____ How long have you been using tobacco? Months: Years: If yes, are you ready to quit or cut back on tobacco? ☐ Yes ☐ No Are you exposed to second-hand smoke? ☐ Yes ☐ No	Advised to quit? ☐ Yes ☐ No Referred? ☐ Yes ☐ No
		10. Have you had any problems with increased moodiness or depression?	
		11. Have you noticed any changes in your complexion or any other skin problems?	
		12. When was the first day of your last period?	
		13. What type of birth control are you using now? For how long?	
		14. Are you using this method correctly?	
		15. Would you prefer another method of birth control?	
		16. Are you aware of Emergency Contraception (the morning after pill)?	
		17. Do you have spotting/bleeding between periods? Do you skip periods?	Extended Contraception Use? ☐ Yes ☐ No
		18. Are you having sex? ☐ men ☐ women ☐ vaginal ☐ anal ☐ oral If yes, how often do you use condoms? ☐ sometimes ☐ always ☐ never	
		19. Have you noticed any signs of vaginal infection? ☐ Burning ☐ Discharge ☐ Itching ☐ Odor ☐ Bumps or Sores ☐ Pain with sex	
		20. How many sexual partners have you had in the last 60 days? _____ Since last exam? Date of last intercourse? Lifetime? Length of current relationship?	
		21. Have any of your past/present partners had a history of: ☐ Injectable drug use ☐ Multiple partners ☐ Bisexuality ☐ Sexually transmitted infections and/or HIV ☐ N/A	
		22. Do you use alcohol? If yes, how much? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	
		23. Do you use street drugs (marijuana, cocaine, crank, methamphetamine, other)? If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	
		24. Do you use seat belts? ☐ Always ☐ Sometimes ☐ Never	
		25. Do you have any other questions or problems? (health, sexuality, nutrition, etc.)	

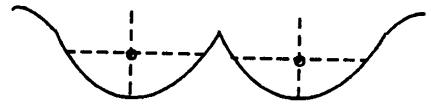
Name (Print)	Date of Birth	Client Number

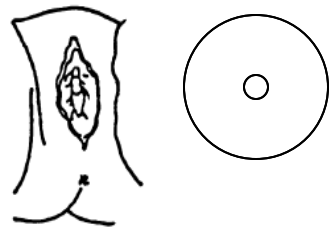
STAFF USE: SAB _____ EAB _____ Gravida _____ Para _____	Hx of Abnormal Pap: ☐ Yes ☐ No	Immunizations Reviewed: ☐ Yes ☐ No	Victim Assessment:	Required Adolescent Counseling (parental involvement and avoidance of sexual coercion):	Pre-Exam Interview:

OBJECTIVE DATABASE

x If Normal

26. BP HT WT BMI		Waist Circumference	
27. Skin/Hair/Nails			
28. Thyroid			
29. Breasts			
30. Heart			
31. Lungs			
32. Abdomen		CVA Tenderness:	
33. External Genitalia			
34. Vagina		Discharge:	
35. Cervix			
36. Uterus Size/Shape		Position:	
37. Adnexae			
38. Rectovaginal			
39. Lower Extremities		IUD Strings Seen? ☐ Yes ☐ No ☐ NA	
40. Other Findings			





Laboratory	X if Done	Results
41. Hct or Hgb		
42. Pregnancy Test		
43. Pap Smear	☐ A ☐ R	
44. Gonorrhea Screen		
45. Chlamydia Screen		
46. HIV Screen		
47. Vaginal Wet Mount		
48. Urine Analysis		

Plans (Methods)			
49. Orals	☐	Brand:	# Prescribed:
50. IUD	☐	Type:	
51. NFP	☐	Type:	
52. Diaphragm	☐	Type:	Size:
53. Injectable	☐		
54. Implantable	☐		
55. Spermicide	☐		
56. Condoms	☐		
57. Other	☐	Specify Method:	
58. ECP	☐		
59. Nuvaring	☐		
60. Patch	☐		

Problems/Comments/Referrals

Post - exam interview? ☐ Yes ☐ No	Signature (Clinician)	Date:
Reason for Visit		

Name (Print)	Age	Date of Birth	Client Number