

**McLaren Print System Order**

Order No: 61526 Reprint Previous Order No: 5512  
 Order Date: 2021-04-05  
 User: Michele Lubick  
 Phone: 586-263-0320

Ship Location: McLaren Macomb Family Medicine-Michele  
 16700 21 Mile Rd., Suite 101  
 Macomb, MI 48044

**Forms**

Quantity: 100  
 Paragon Dept No: 71600  
 Dept Name: McLaren Macomb Family Medicine  
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-123  
 Item Description: Gynecological History & Examination  
 Revision Date: 8/2013  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

McLaren Medical Group  
 GYNECOLOGICAL HISTORY & EXAMINATION

DATE \_\_\_\_\_ AGE \_\_\_\_\_

VITALS: Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

Chief Complaint \_\_\_\_\_ LMP \_\_\_\_\_  
 Signature \_\_\_\_\_

History of Present Illness: \_\_\_\_\_  Questionnaire / ROS reviewed

EXAMINATION	Date of Last
Vital Signs reviewed <input type="checkbox"/> General Appearance _____	Pap _____ Mamm _____ Bone Density _____
Orientation <input type="checkbox"/> time <input type="checkbox"/> place <input type="checkbox"/> person _____	NOTES/ASSESSMENT/PLAN:
Mood/Affect <input type="checkbox"/> normal <input type="checkbox"/> depressed _____	
H _____ <input type="checkbox"/> anxious <input type="checkbox"/> agitated _____	
T Neck: Neck/Thyroid _____	
R RESPIRATORY: WNL <input type="checkbox"/> Y <input type="checkbox"/> N _____	
C CARDIOVASCULAR: WNL <input type="checkbox"/> Y <input type="checkbox"/> N _____	
BREASTS: Symmetrical <input type="checkbox"/> Y <input type="checkbox"/> N _____	
I Discharge <input type="checkbox"/> Y <input type="checkbox"/> N Lumps/Masses <input type="checkbox"/> Y <input type="checkbox"/> N _____	
A Nipples <input type="checkbox"/> Everted <input type="checkbox"/> Inverted _____	
N Other _____	
GASTROINTESTINAL: Liver/Spleen _____	
A Abdominal masses / tenderness <input type="checkbox"/> Y <input type="checkbox"/> N _____	
S Hemia <input type="checkbox"/> Y <input type="checkbox"/> N _____	
E Rectum (Anus) WNL <input type="checkbox"/> Y <input type="checkbox"/> N Hemorrhoids <input type="checkbox"/> Y <input type="checkbox"/> N _____	
L LYMPHATIC: Neck <input type="checkbox"/> non-palpable _____	
A Axilla <input type="checkbox"/> non-palpable Groin <input type="checkbox"/> non-palpable _____	
M PELVIC: External genitalia _____	
R Uterus/mass WNL <input type="checkbox"/> Y <input type="checkbox"/> N _____	
N Uterus WNL <input type="checkbox"/> Y <input type="checkbox"/> N Cervix WNL <input type="checkbox"/> Y <input type="checkbox"/> N _____	
T Vagina WNL <input type="checkbox"/> Y <input type="checkbox"/> N Uterus WNL <input type="checkbox"/> Y <input type="checkbox"/> N _____	
Adnexa WNL <input type="checkbox"/> Y <input type="checkbox"/> N _____	

Time \_\_\_\_\_ mins.  50% of time counseling

Signature of Provider \_\_\_\_\_ Date/Time \_\_\_\_\_

GYNECOLOGICAL HISTORY AND EXAMINATION