SCOTT KEYCENTER

# GYNECOLOGIAL EXAMINATION RECORD

A. _____ B. _____

LAST NAME FIRST NAME MIDDLE DATE OF BIRTH/AGE

C. _____

ADDRESS CITY/COUNTY STATE ZIP CODE

D. _____

TELEPHONE NUMBER

USING BIRTH CONTROL: ( ) YES ( ) NO

What type: ( ) Pill ( ) IUD ( ) Hysterectomy ( ) Tubal Ligation

A gynecological Examination was performed on the above named patient on: Date: _____

Date of Pap Smear: _____

Result of Pap Smear: _____

The interval between gynecological examinations and/or Pap Smears will be determined by the physician.

RECOMMENDATIONS:

_____

_____

_____

_____

(Please Print)

Name and Title of Examiner: _____

Signature: _____

Address: _____ Phone: _____

Date: _____