Sample history and examination form

Tips for talking with clients

- Show that you are listening and that you care: Make eye contact, acknowledge her feelings (for example, you can nod, and you can say "I understand" or "I see how you feel").
- Sit at the same level as the client.
- Respect her dignity. Do not express negative judgments about her or others.
- Be gentle. Encourage her to answer but do not insist.
- Ask one question at a time. Speak simply and clearly. Ask for clarification or detail if needed.
- Give her time to answer and allow silences. Do not rush.

CONFIDENTIAL CODE:

Medical History and Examination Form for Sexual Assault

May I ask you some questions so that we can decide how to help you? I know that some things may be difficult to talk about. Please try to answer. But you do not have to answer if it is too difficult.

1. GENERAL INFORMATION

<table>
<tr><td colspan="2">Family name</td><td colspan="2">Given name</td></tr>
<tr><td colspan="4">Address</td></tr>
<tr><td>Sex</td><td colspan="2">Date of birth ______ / ______ / ______
DD MM YY</td><td>Age</td></tr>
<tr><td colspan="2">Date and time of examination
______ / ______ / ______ ; ________
DD MM YY</td><td colspan="2">In the presence of</td></tr>
</table>

2. GENERAL MEDICAL INFORMATION

Existing health problems

Do you have any ongoing health problems? ☐ Yes ☐ No

If "yes", what health problems?

Do you have any allergies? If so, to what?

Are you taking any medicines, herbs or potions?

Vaccination status

Have you been vaccinated for…

…tetanus? ☐ Yes When? ______ / ______ / _____
DD MM YY

☐ No ☐ Does not know

…hepatitis B? ☐ Yes ☐ No ☐ Does not know

HIV/AIDS status

Have you had an HIV test? ☐ Yes When? _____ / ______ / _____
DD MM YY

☐ No

If "yes", may I ask the result? ☐ Negative
☐ Positive
☐ Not disclosed

3. DESCRIPTION OF INCIDENT

Date of incident: _____ / _____ / ____
DD MM YY

Time of incident:

Could you tell me what happened, please?

Has something like this happened before? ☐ Yes ☐ No

If "yes": When was that? _____ / _____ / ____
DD MM YY

Was the same person responsible this time? ☐ Yes ☐ No

Physical violence	**Describe type and location on body**
Type (beating, biting, pulling hair, strangling, etc.)	
Use of restraints	
Use of weapon(s)	
Drugs/alcohol involved	

In cases of sexual assault

Penetration	**Yes**	**No**	**Not sure**	**Describe (oral, vaginal, anal)**
Penis	☐	☐	☐	
Finger	☐	☐	☐	
Other (describe)	☐	☐	☐	
Ejaculation	☐	☐	☐	
Condom used	☐	☐	☐	

Actions after assault

After this happened, did you …

Vomit?	☐ Yes	☐ No
Urinate?	☐ Yes	☐ No
Defecate?	☐ Yes	☐ No
Brush your teeth?	☐ Yes	☐ No
Rinse your mouth?	☐ Yes	☐ No
Change your clothes?	☐ Yes	☐ No
Wash or bathe?	☐ Yes	☐ No
Use a tampon or pad?	☐ Yes	☐ No

4. GYNAECOLOGICAL HISTORY

Are you using a contraceptive method?

☐ IUD	☐ Sterilization
☐ Pill	☐ Condom
☐ Injectable	☐ Other ______________________

Were you using this method when the incident happened?

☐ Yes ☐ No

Menstruation and pregnancy

When did your last menstrual bleeding start? ____ / _____ / ____
DD MM YY

Were you menstruating at the time of event?

☐ Yes ☐ No

Do you think you might be pregnant? ☐ Yes ☐ No If "yes", number of weeks pregnant: ____ weeks
Have you ever been pregnant? ☐ Yes ☐ No If "yes", how many times? _______ times
History of consenting intercourse (only if samples taken for DNA analysis in assault case)
When was the last time you had sex willingly? ____ / ____ / ____ DD MM YY Who was it? (for example, husband, boyfriend, stranger)

5. HEAD-TO-TOE PHYSICAL EXAMINATION

Weight	Height	Pubertal stage (pre-pubertal, pubertal, mature)	
Pulse rate	Blood pressure	Respiratory rate	Temperature

Physical findings Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae (signs of bleeding under the skin), marks, etc. Document type, size, colour, form and other particulars. Describe as completely and accurately as possible. Do not interpret the findings.	
Head and face	Mouth and nose

Eyes and ears	Neck
Chest	Back
Abdomen	Buttocks
Arms and hands	Legs and feet

6. GENITAL AND ANAL EXAMINATION

<table>
<tr><td colspan="2">Vulva/scrotum</td><td colspan="2">Introitus and hymen</td><td colspan="2">Anus</td></tr>
<tr><td>Vagina / penis</td><td colspan="2">Cervix</td><td colspan="2">Bimanual / rectovaginal examination</td><td>Evidence of female genital mutilation? (where relevant)
☐ Yes ☐ No</td></tr>
<tr><td colspan="6">Position of patient (supine, prone, knee–chest, lateral)</td></tr>
<tr><td colspan="3">For genital examination</td><td colspan="3">For anal examination</td></tr>
</table>

7. MENTAL STATE

Appearance (Clothing, hair cared for or in disarray? Distracted or agitated? Restless? Signs of intoxication or misuse of drugs?)

Mood

Ask: *How have you been feeling?*

Also observe. For example, is she calm, crying, angry, anxious, very sad, without expression?

Speech (Silent? Speaking clearly or with difficulty? Confused ? Talking very fast or very slow?)

Thoughts

Ask: *Have you had thoughts about hurting yourself?*

☐ Yes ☐ No

Are there bad thoughts or memories that keep coming back?

☐ Yes ☐ No

Are you seeing the event over and over in your mind?

☐ Yes ☐ No

8. INVESTIGATIONS DONE

Type and location	Examined / sent to laboratory	Result

9.EVIDENCE TAKEN

Type and location	Sent to… / stored	Collected by / date

10. TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and comments
STI prevention/treatment	☐	☐	
Emergency contraception	☐	☐	
Wound treatment	☐	☐	
Tetanus prophylaxis	☐	☐	
Hepatitis B vaccination	☐	☐	
Post-exposure prophylaxis for HIV	☐	☐	
Other	☐	☐	

11. COUNSELLING, REFERRALS, FOLLOW-UP

Client plans to report to police *OR* has already made report? ☐ Yes ☐ No	
Client has a safe place to go? ☐ Yes ☐ No	Has someone to accompany her/him? ☐ Yes ☐ No
Counselling provided:	
Referrals made (for example, housing, mental health care, support group):	
To:	Purpose:
Follow-up agreed with client? ☐ Yes ☐ No Date of next visit:: _______ / _______ / ________ DD MM YY	

Name of health-care provider conducting the examination / interview:

Title: ____________________________________

Printed name: ____________________________

Signature: _______________________________

Date: _______ / _______ / ________
DD MM YY

Excerpted from World Health Organization, Health care for woman subjected to intimate partner violence or sexual violence: A Clinical Handbook, field-testing version, 2014. Pp 45-47.