GENITAL DISCHARGE - FEMALE

Subjective Data:

Allergies: ___________________________

Chief complaint: ___________________________________________________________________________________

Onset:_________ ☐ New Onset ☐ Chronic ☐ Recurrence

History:

Sexually transmitted disease: ☐ None ☐ Gonorrhea ☐ Syphilis ☐ Herpes ☐ Chlamydia ☐ Venereal warts

Antibiotic therapy: When: ____________ Name of medication: ____________________________________________

Last sexual intercourse: _____________ Last menstrual period: ______________ Last vaginal infection: ______

Associated Symptoms:

Change in voiding: ☐ Burning / painful urination ☐ Frequency ☐ Urgency ☐ Dribbling ☐ Inability to void

Lumbosacral back pain or mid-abdominal pain: ☐ Yes ☐ No If “Yes” describe: __________________________

Radiation of pain: ☐ Yes ☐ No If “Yes” describe: ________________________________________ Pain scale: (0-10)

☐ Itching ☐ Foul odor ☐ Burning ☐ Redness ☐ Edema ☐ Discharge: Describe: ______________________

Objective Data: (clinically indicated VS)

BP __________ Pulse _________ Resp. ________ Temp. ________ Wt._______ O2 sats._________ FSBS: ___________

Abdomen: ☐ Soft ☐ Slightly firm ☐ Rigid ☐ Distended

Bowel sound: ☐ Normal ☐ Hyperactive ☐ Hypoactive ☐ Absent

Mucus membrane: ☐ Moist ☐ Dry ☐ Parched

Turgor: ☐ Normal ☐ Decreased

Urine: ☐ Clear ☐ Dark ☐ Cloudy ☐ Bloody ☐ Foul odor

Appearance: ☐ No distress ☐ Mild distress ☐ Moderate distress ☐ Severe distress

CONTACT HEALTH CARE PROVIDER IMMEDIATELY IF: Health care provider must be called if not on site or if after clinic hours.

☐ Temp > 101 ☐ Foul odor ☐ Abdominal pain

REFER TO HEALTH CARE PROVIDER IF: If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.

☐ Any discharge or genital lesions are present ☐ Frequent recurrence ☐ Inmate not responding to interventions

Health Care Provider: ____________________ Time Notified: ______ Orders Received for Treatment: ☐ Yes ☐ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

☐ Check in assessment only for health care providers visit.

☐ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.

☐ Clean catch urine specimen.

☐ Dip-stick urine.

☐ Anti-fungal vaginal cream or suppositories. (This will require an order from the health care provider)

☐ Hydrocortisone cream 1% 2 times a day for 10 days PRN to external vaginal area for symptomatic relief of itching or perineal irritation.

☐ Education/Intervention: Instructed on proper hygiene care, methods to reduce irritation, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: __________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Health Care Provider Signature/Credentials: _________________________________ Date: _______ Time: ______

RN/LPN Signature/credentials: _________________________________ Date: _______ Time: ______

Inmate Name (Last, First) DOC #