

State of California
California Office of Emergency Services
(www.oes.ca.gov)

**FORENSIC MEDICAL REPORT:
NONACUTE (>72 HOURS)
CHILD/ADOLESCENT SEXUAL ABUSE
EXAMINATION**

CAL OES 2-925



For copies of this form or assistance in completing the CAL OES 2-925, please contact
California Clinical Forensic Medical Training Center at:
(916) 930-3080 or go to: www.ccfmtc.org

**FORENSIC MEDICAL REPORT: NONACUTE (>72 HOURS)
CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION
STATE OF CALIFORNIA
CALIFORNIA OFFICE OF EMERGENCY SERVICES**

Cal OES 2-925

Confidential Document

Patient Identification

A. GENERAL INFORMATION (print or type) Name of Medical Facility:

1. Name of patient _____ Patient ID number _____

2. Address _____ City _____ County _____ State _____ Telephone _____

3. Age	DOB	Gender	Ethnicity	Date/time of arrival	Date/time of discharge

4. Name of : Mother Stepmother Guardian Address _____ City _____ County _____ State _____ Telephone W: _____ H: _____

5. Name of : Father Stepfather Guardian Address _____ City _____ County _____ State _____ Telephone W: _____ H: _____

6. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. REPORTING AND AUTHORIZATION Jurisdiction (city county other):

1. Telephone report made to _____ Name _____ Agency _____ ID number _____ Telephone _____

Law Enforcement and/or _____

Child Protective Services _____

2. Responding Personnel (to medical facility) _____ Name _____ Agency _____ ID number _____ Telephone _____

Law Enforcement and/or _____

Child Protective Services _____

3. Assigned Investigator (if known) _____ Name _____ Agency _____ ID number _____ Telephone _____

Law Enforcement _____

Child Protective Services _____

4. Authorization for evidential exam requested by law enforcement or child protective services agency

I request a forensic medical examination for suspected sexual abuse at public expense.

Telephone Authorization	Law enforcement officer	ID number	Child Protective Services
Agency: _____ Authorizing party: _____ ID number: _____ Date/time: _____	<input type="checkbox"/>	_____	<input type="checkbox"/>

Telephone _____ Date _____ Time _____ Case number _____

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN Note: Parental consent is not required for a suspected child sexual abuse examination if the child is in protective custody. Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection for sexual assault without parental consent. See instructions regarding parental notification requirements for minors.

- I hereby consent to a forensic medical examination for evidence of sexual abuse. I understand that collection of evidence may include photographing injuries and that these photographs may include the anal-genital area (private parts). I further understand that medical providers are required to notify child protective authorities of known or suspected child abuse; and, if child abuse is found or suspected, this form and any evidence obtained will be released to a child protective agency.
- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime (VOC) Restitution Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining/rehabilitation.
- I understand that data without patient identity may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological studies.

Signature _____ Patient Parent Guardian

DISTRIBUTION OF Cal OES 2-925

Original – Law Enforcement Copy – Child Protective Services Copy – Medical Facility Records

D. PATIENT HISTORY

1. Record time or time frame of the incident(s)	Date(s)	Time or time frame
<input type="checkbox"/> More than 72 hours		
<input type="checkbox"/> Multiple incidents over time		

2. Record patient's name for:	3. Alleged perpetrator(s) name(s)	Age	Gender	Ethnicity	Relationship to Patient	
					Known	Unknown
Female genitalia						
Male genitalia	#1.		M F			
Breasts	#2.		M F			
Anus	#3.		M F			

E. ACTS DESCRIBED BY HISTORIAN

Name of historian	Relationship to patient	History obtained by:	Telephone	Agency	<input type="checkbox"/> Not applicable
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	No	Yes	Attempted	Unsure	N/A	Describe pain and/or bleeding and additional pertinent history:
Genital/vaginal contact/penetration by:						
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Object (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal contact/penetration by:						
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Object (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral copulation of genitals:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral copulation of anus:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal/genital fondling:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-genital act(s)? <input type="checkbox"/>						
If yes: <input type="checkbox"/> Fondling <input type="checkbox"/> Licking <input type="checkbox"/> Kissing <input type="checkbox"/> Suction Injury <input type="checkbox"/> Biting						
Other acts? (Describe) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
Did ejaculation occur? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
If yes, note location(s):						
<input type="checkbox"/> Mouth	<input type="checkbox"/> Vagina	<input type="checkbox"/> Body surface	<input type="checkbox"/> On bedding			
<input type="checkbox"/> Anus/Rectum	<input type="checkbox"/> On clothing	<input type="checkbox"/> Other				
Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>						
If yes, note type/brand: <input type="checkbox"/> Foam <input type="checkbox"/> Jelly <input type="checkbox"/> Lubricant <input type="checkbox"/> Condom						
Were force or threats used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Force <input type="checkbox"/> Threats <input type="checkbox"/>						
Were pictures/videotapes taken <input type="checkbox"/> or shown <input type="checkbox"/> ? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>						
If yes, note type(s): <input type="checkbox"/> Pictures <input type="checkbox"/> Videotapes						
Were drugs <input type="checkbox"/> or alcohol <input type="checkbox"/> used? <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/>						
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/>						
Lapse of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/>						
Vomited after act(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>						
Behavioral changes in patient? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>						

***Collection of urine toxicology sample (<96 hours) is recommended according to local policy.**

F. ACTS DESCRIBED BY PATIENT

1. Acts disclosed by patient to: Law Enforcement Officer
 Medical Examiner Multi-disciplinary Interview Team
 Social Worker Other:

Patient Identification

	No	Yes	Attempted	Unsure	N/A	2. Describe pain and/or bleeding (using exact patient's words) and additional pertinent history:
Genital/vaginal contact/penetration by:						
Penis	<input type="checkbox"/>	_____				
Finger	<input type="checkbox"/>	_____				
Object (Describe)	<input type="checkbox"/>	_____				
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal contact/penetration by:						
Penis	<input type="checkbox"/>	_____				
Finger	<input type="checkbox"/>	_____				
Object (Describe)	<input type="checkbox"/>	_____				
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral copulation of genitals:						
Of patient by assailant	<input type="checkbox"/>	_____				
Of assailant by patient	<input type="checkbox"/>	_____				
Oral copulation of anus:						
Of patient by assailant	<input type="checkbox"/>	_____				
Of assailant by patient	<input type="checkbox"/>	_____				
Anal/genital fondling:						
Of patient by assailant	<input type="checkbox"/>	_____				
Of assailant by patient	<input type="checkbox"/>	_____				
Non-genital act(s)?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	_____
If yes: <input type="checkbox"/> Fondling <input type="checkbox"/> Licking <input type="checkbox"/> Kissing <input type="checkbox"/> Suction Injury <input type="checkbox"/> Biting						_____
Other acts? (Describe)	<input type="checkbox"/>	_____				
Did ejaculation occur?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, note location(s):						_____
<input type="checkbox"/> Mouth <input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> On bedding						_____
<input type="checkbox"/> Anus/Rectum <input type="checkbox"/> On clothing <input type="checkbox"/> Other						_____
Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes					<input type="checkbox"/>	_____
If yes, note type/brand: <input type="checkbox"/> Foam <input type="checkbox"/> Jelly <input type="checkbox"/> Lubricant <input type="checkbox"/> Condom						_____
Were force or threats used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Force <input type="checkbox"/> Threats					<input type="checkbox"/>	_____
Were pictures/videotapes taken <input type="checkbox"/> or shown <input type="checkbox"/> ? <input type="checkbox"/> No <input type="checkbox"/> Yes					<input type="checkbox"/>	_____
If yes, note type(s): <input type="checkbox"/> Pictures <input type="checkbox"/> Videotapes						_____
Were drugs <input type="checkbox"/> or alcohol <input type="checkbox"/> used? <input type="checkbox"/> No <input type="checkbox"/> Yes*					<input type="checkbox"/>	_____
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes*					<input type="checkbox"/>	_____
Lapse of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes*					<input type="checkbox"/>	_____
Vomited after act(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes					<input type="checkbox"/>	_____
Behavioral changes? <input type="checkbox"/> No <input type="checkbox"/> Yes					<input type="checkbox"/>	_____

*Collection of urine toxicology sample (<96 hours) is recommended according to local policy.

G. MEDICAL HISTORY (to be completed by medical personnel)

1. Name of person providing history	Relationship to patient		9. Other symptoms disclosed	By patient:		By historian:		
	No	Yes		No	Yes	No	Yes	Unk
2. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of physical findings?	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/pelvic pain	<input type="checkbox"/>				
3. Any other pertinent medical conditions that may affect the interpretation of physical findings?	<input type="checkbox"/>	<input type="checkbox"/>	Pain on urination	<input type="checkbox"/>				
4. Any pre-existing physical injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Genital discomfort or pain	<input type="checkbox"/>				
5. Any previous history of physical abuse and/or neglect?	<input type="checkbox"/>	<input type="checkbox"/>	Genital itching	<input type="checkbox"/>				
6. Any previous history of sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>	Genital discharge	<input type="checkbox"/>				
7. Other intercourse? (For adolescents only)	<input type="checkbox"/>	<input type="checkbox"/>	Genital bleeding	<input type="checkbox"/>				
If yes, anal (within past 5 days)? When _____	<input type="checkbox"/>	<input type="checkbox"/>	Rectal discomfort or pain	<input type="checkbox"/>				
vaginal (within past 5 days)? When _____	<input type="checkbox"/>	<input type="checkbox"/>	Rectal itching	<input type="checkbox"/>				
If yes, did ejaculation occur? Where _____	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding Constipation	<input type="checkbox"/>				
If yes, was a condom used?	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>				
8. Menstrual periods?	<input type="checkbox"/>	<input type="checkbox"/>						
If yes, age of menarche: _____ Last menstrual period: _____								

H. GENERAL PHYSICAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. BP	Pulse	Resp	Temp	Height	Weight	2. Date/time examination		
						Started	Completed	
3. Female Tanner Stage – Breast				1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Describe general demeanor and relevant statements made during exam.								
5. Conduct a physical examination. <input type="checkbox"/> Findings <input type="checkbox"/> No Findings								
General exam within normal limits: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe:								

Patient Identification

Diagram A

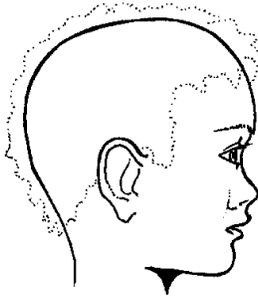


Diagram B

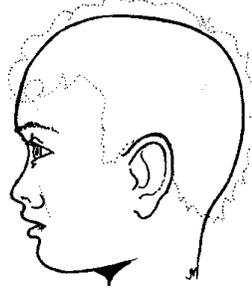


Diagram C

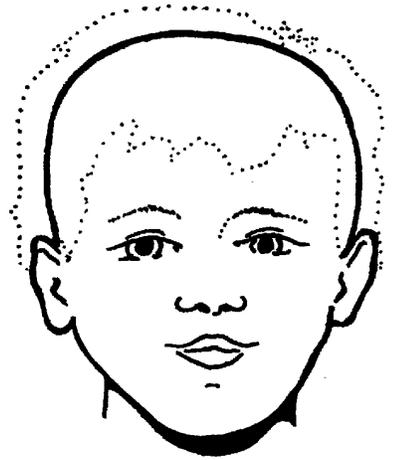


Diagram D

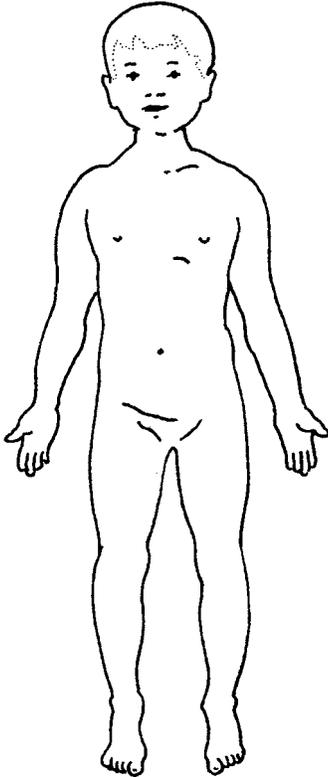


Diagram E

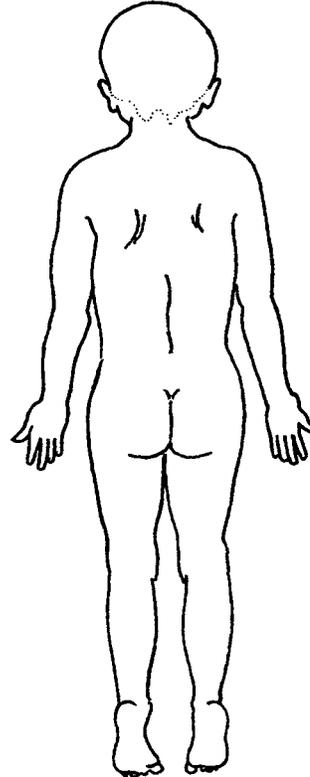
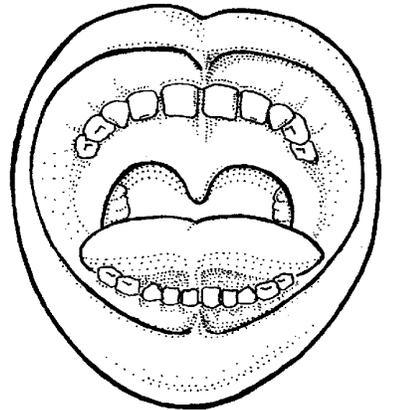


Diagram F



LEGEND: Types of Findings

AB Abrasion	BU Burn	DI Discharge	HC Hymenal Cleft	OSC Other Skin Condition	PGW Possible Genital Wart	SW Swelling
AHT Absent Hymenal Tissue	CV Congenital Variation	EC Ecchymosis (bruise)	IN Induration	OT Other	SH Submucosal Hemorrhage	TE Tenderness
AL Anal Laxity	DE Debris	ER Erythema (redness)	LA Laceration	PW Perianal Wart	SI Suction Injury	VL Vesicular Lesion
BI Bite	DF Deformity	FB Foreign Body	OI Other Injury (describe)	PE Petechiae		
GT Granulation Tissue						

Locator #	Type	Description	Locator #	Type	Description

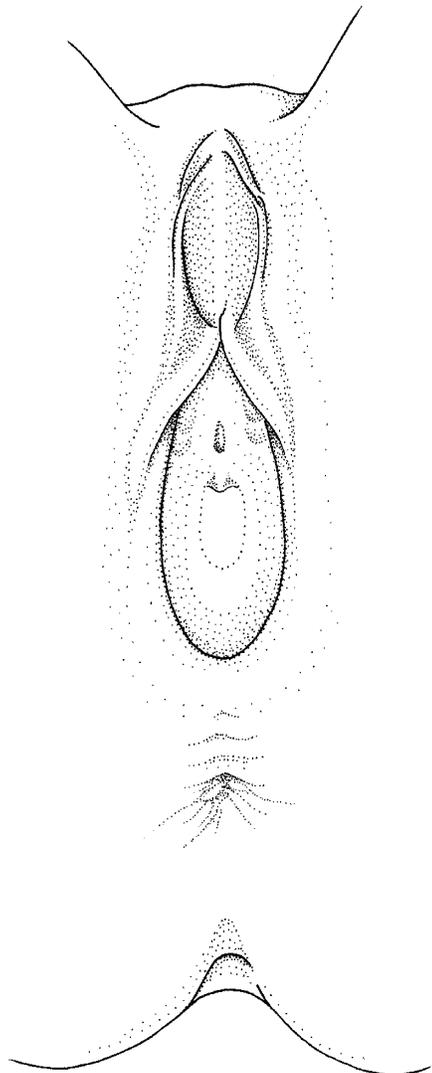
I. EXAMINATION OF THE EXTERNAL GENITALIA AND PERINEAL AREA

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Use a colposcope or employ other means of magnification.
2. Examine the genital structures.
 - See page 5 of instructions for diagrams of the genital structures.
 - Use exam techniques described in instructions.
 - Diagram the position that best illustrates your findings.

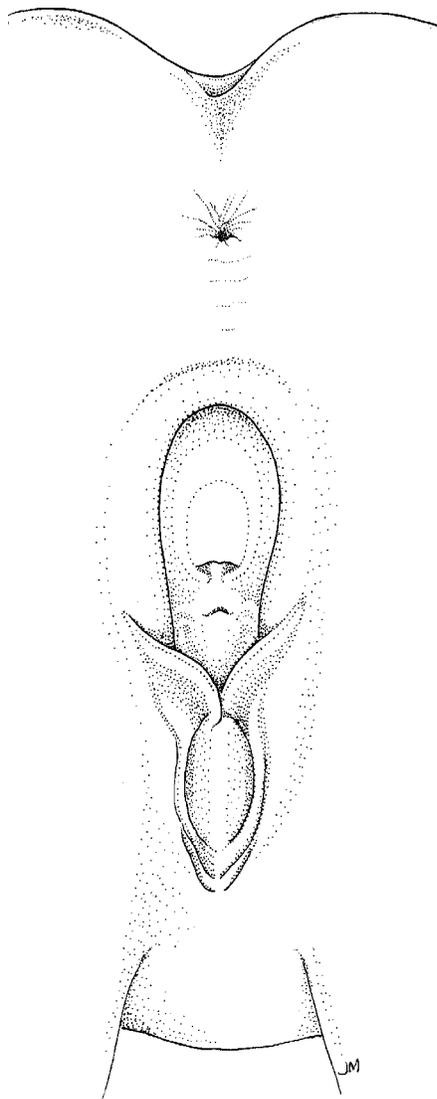
Patient Identification

Diagram G



Supine

Diagram H



Knee-Chest

Diagram I

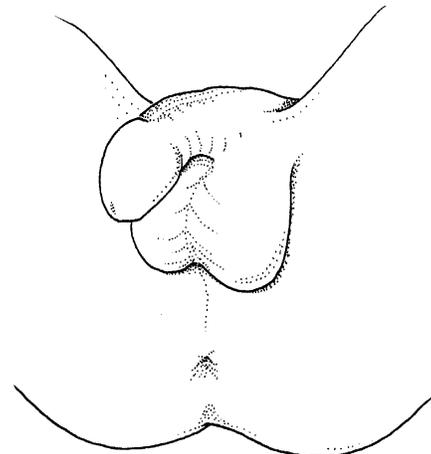
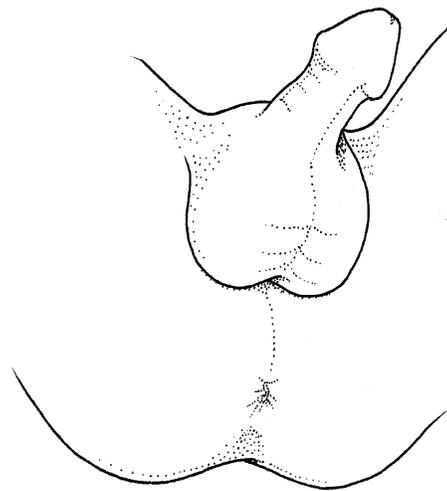


Diagram J



Penis

LEGEND: Types of Findings

AB Abrasion	BU Burn	DI Discharge	HC Hymenal Cleft	OSC Other Skin Condition	PGW Possible Genital Wart	SW Swelling
AHT Absent Hymenal Tissue	CV Congenital Variation	EC Ecchymosis (bruise)	IN Induration	OT Other	SH Submucosal Hemorrhage	TE Tenderness
AL Anal Laxity	DE Debris	ER Erythema (redness)	LA Laceration	PW Perianal Wart	SI Suction Injury	VL Vesicular Lesion
BI Bite	DF Deformity	FB Foreign Body	OI Other Injury (describe)	PE Petechiae		

Locator #	Type	Description	Locator #	Type	Description

J. ANAL-GENITAL FINDINGS

1. Exam method:
 Direct visualization Colposcope Other magnification

2. General Female/Male WNL ABN Describe

Inguinal adenopathy _____

Perineum _____

3. Genital Tanner Stage 1 2 3 4 5

4. Female Genitalia

Exam positions/methods:	Separation	Traction	Knee
chest			
Supine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Saline/water <input type="checkbox"/> Moistened swab <input type="checkbox"/> Catheter <input type="checkbox"/> Other: _____			

	WNL	ABN	Describe
Labia majora	<input type="checkbox"/>	<input type="checkbox"/>	
Labia minora	<input type="checkbox"/>	<input type="checkbox"/>	
Clitoral hood	<input type="checkbox"/>	<input type="checkbox"/>	
Perihymenal tissues (vestibule)	<input type="checkbox"/>	<input type="checkbox"/>	
Hymen <input type="checkbox"/> Supine <input type="checkbox"/> Prone	<input type="checkbox"/>	<input type="checkbox"/>	
Record morphology:			
<input type="checkbox"/> Annular			_____
<input type="checkbox"/> Crescentic			_____
<input type="checkbox"/> Imperforate			_____
<input type="checkbox"/> Septate			_____
Fossa navicularis	<input type="checkbox"/>	<input type="checkbox"/>	
Posterior fourchette	<input type="checkbox"/>	<input type="checkbox"/>	
Vagina (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	
Cervix (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: _____			

5. Male Genitals WNL ABN Describe

	WNL	ABN	Describe
Penis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Circumcised	<input type="checkbox"/>		_____
Uncircumcised	<input type="checkbox"/>		_____
Foreskin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glans Penis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Penile Shaft	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urethral meatus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scrotum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Testes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discharge <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: _____			

6. Female/Male Anus and Rectum

Exam positions	Observation	Observation with traction
Supine	<input type="checkbox"/>	<input type="checkbox"/>
Supine knee chest	<input type="checkbox"/>	<input type="checkbox"/>
Prone knee chest	<input type="checkbox"/>	<input type="checkbox"/>
Lateral recumbent	<input type="checkbox"/>	<input type="checkbox"/>
Exam methods: <input type="checkbox"/> Moistened swab <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Anoscopy		

	WNL	ABN	Describe:
Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perianal skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal verge/folds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectum	<input type="checkbox"/>	<input type="checkbox"/>	_____

Anal dilation <input type="checkbox"/> No <input type="checkbox"/> Yes If yes: <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed			
Stool present in rectal ampulla <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined			

K. FINDINGS AND INTERPRETATION

1. Anal-Genital Findings

Normal anal-genital exam

Abnormal anal-genital exam

Indeterminate anal-genital exam

2. Assessment of Anal-Genital Findings

Consistent with history

Inconsistent with history

Limited/Insufficient history

3. Interpretation of Anal-Genital Findings

Normal exam: can neither confirm nor negate sexual abuse

Non specific: may be caused by sexual abuse or other mechanisms

Sexual abuse is highly suspected

Definite evidence of sexual abuse and/or sexual contact.

4. Need further consultation/investigation

5. Lab results or photo review pending (may alter assessment)

6. Additional comments regarding findings, interpretations, and recommendations.

L. MEDICAL LAB TESTS PERFORMED

STD Cultures	GC	Chlamydia	Other	Describe	Taken by
Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Vestibular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Vaginal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cervical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Penile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Wet mount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serology	Syphilis <input type="checkbox"/>	HIV <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	_____	_____
Pregnancy test	Blood <input type="checkbox"/>	Urine <input type="checkbox"/>		_____	_____
Other test(s) _____					

M. TOXICOLOGY

Urine Toxicology No Yes Taken by: _____

N. PHOTO DOCUMENTATION METHODS

	No	Yes	Colposcope/35mm	Macrolens/35mm	Colposcope/Videocamera	Other Optics	Photographed by:
Body	<input type="checkbox"/>	_____					
Genitals	<input type="checkbox"/>	_____					

O. PRINT NAMES OF PERSONNEL INVOLVED

History taken by:	Exam performed by:	Telephone:	Signature of Examiner:	License No.
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