ADULT/ADOLESCENT
MEDICAL FORENSIC EXAMINATION RECORD
Confidential Document

Patient Identification

Name of Medical Facility:

A. GENERAL INFORMATION (print or type)

Name of Patient			**Preferred Name**
Age	**DOB**	**MRN**	**Discharge date**
Arrival date		**Arrival time**	**Discharge time**

Mode: ☐Private Vehicle ☐Ambulance ☐Law Enforcement ☐Other:

B. REPORTING AND AUTHORIZATION **Jurisidiction:** ☐City ☐County ☐Other:

Law Enforcement Agency **Case Number**

Detective Name **Phone** **Email**

Patient declined to report to LE ☐

DCS/APS Involvement ☐Yes ☐No **Name** **Phone** **Email**

C. PATIENT HISTORY OF EVENT(S) **If pediatric, name of person providing history/relationship:**

☐See attached narrative

D. PAST MEDICAL HISTORY **(Attach additional documentation if needed)** **Person providing history/relationship:**

Current Physician(s)	**Current Medical Conditions**	
Past Medical Conditions	**Current thoughts of self-harm, suicide or homicide:** ☐Yes ☐No	
History of previous emotional, physical or sexual abuse or neglect: ☐Yes ☐No		
Current Medications	**Medication Allergies**	**Other Allergies** (Food, Latex, Topical)
Prior Hospitalizations	**Prior Surgeries**	**Emergency Dept. Visits Within Past Year**

Last Visit to Doctor	**Immunizations Current?** ☐Yes ☐No	**Date of Last Tetanus**	**Hep B Vaccination** ☐Yes ☐No
Date of Last Menstrual Period	**Age of Onset**	**Age at Cessation or Last Period**	

Birth Control ☐Yes (list) _____ ☐No

OB/Gyn Hx: ☐Tubal Ligation ☐Hysterectomy ☐Partial ☐Total Gravida #_____ Para #_____ ☐Other: ☐Vaginal Deliveries #_____

Anal/Genital Surgeries or Recent Injury/Infection to Anal/Genital: ☐No ☐Yes (list) _____

Pre-existing Injuries or Complaints Not Caused by This Event:

☐None ☐Pain ☐Bruising ☐Bleeding ☐Swelling ☐Injuries (list) _____

E. SOCIAL HISTORY

Employment ☐Full-time ☐Part-time ☐Unemployed ☐Retired ☐Stay-at-Home Caregiver ☐Other_____

Occupation

Does Patient Smoke? ☐No ☐Yes **If Yes:** ☐Tobacco ☐Marijuana ☐Other_____

Does Patient Vape? ☐No ☐Yes **If Yes:** ☐Nicotine ☐Cannabis ☐Other_____

How Long Has Patient Smoked/Vaped?	**How Much Does Patient Smoke/Vape Each Day?**

Does Patient Consume Alcohol? ☐No ☐Yes **If Yes:** Frequency_____ Amount_____

Does Patient Use Street Drugs? ☐No ☐Yes **If Yes:** Drug(s) _____

Frequency _____ Amount _____

F. SEXUAL ORIENTATION / GENDER IDENTITY

Patient's Sexual Orientation ☐Homosexual ☐Heterosexual ☐Bisexual ☐Something Else ☐Don't Know ☐Chose Not to Disclose

Patient's Gender Identity ☐Female ☐Male ☐Transgender Female/Male-to-Female ☐Transgender Male/Female-to-Male ☐Non-Binary/Gender Non-Conforming ☐Other ☐Chose Not to Disclose

Patient's Sex Assigned at Birth ☐Female ☐Male ☐Unknown ☐Not Recorded on Birth Certificate ☐Chose Not to Disclose

Patient's Pronouns ☐She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐Patient's Name ☐Chose Not to Disclose ☐Unknown

Steps Patient Has Taken to Transition, If Any

☐Presentation Aligned With Gender Identity ☐Preferred Name Aligned With Gender Identity ☐Legal Name Aligned With Gender Identity ☐Legal Sex Aligned With Gender Identity ☐Medical or Surgical Intervention

Patient's Future Plans to Transition, If Any

Organs the Patient Currently Has ☐Breasts ☐Cervix ☐Ovaries ☐Uterus ☐Vagina ☐Penis ☐Prostate ☐Testes

Organs Present at Birth or Expected at Birth to Develop

☐Same as Current Organs ☐Breasts ☐Cervix ☐Ovaries ☐Uterus ☐Vagina ☐Penis ☐Prostate ☐Testes

Organs Hormonally Enhanced or Developed ☐Breasts **Organs Surgically Enhanced or Constructed** ☐Breasts ☐Vagina ☐Penis

G. PATIENT'S PRESENTATION

General Physical Appearance

Condition of Clothing

Demeanor of Patient

H. ASSAULT HISTORY

Date and Time Incident Occurred

Location of Assault/Physical Surroundings or Place/Position of Patient During Assault

Prior Physical Assaults with this Assailant? ☐No ☐Yes If Yes, List Any Past Injuries:

Has Any Prior Assault Been With Something Over Mouth or Around Neck? ☐No ☐Yes Describe:

Assailant(s):

NAME	AGE	GENDER	ETHNICITY	RELATIONSHIP TO PATIENT

I. METHODS EMPLOYED BY ASSAILANT

Physical Abuse	No	Yes	Unknown	Describe
Physical Blows: ☐Hit ☐Beat ☐Punched ☐Slapped ☐Kicked ☐Pinching ☐Holding ☐Bites ☐Thrown ☐Pushed	☐	☐	☐	
Weapons: ☐Firearms ☐Knife ☐Blunt Object ☐Other_____	☐	☐	☐	
Burned	☐	☐	☐	
Confined/Restrained	☐	☐	☐	
Strangled/Suffocated (See Section M, Page 8)	☐	☐	☐	
Poisoning	☐	☐	☐	
Involuntary Use of Drugs/Alcohol	☐	☐	☐	
Forced Sexual Relations (See sexual assault documentation)	☐	☐	☐	
Misappropriation of Money	☐	☐	☐	
Prevention from Seeing: ☐Family ☐Social Contacts ☐Mail ☐Phone ☐Medical Providers ☐Legal Providers	☐	☐	☐	
Threats of Harm and Intimidation: ☐Children ☐Patient ☐Family ☐Pet ☐Property ☐Other_____	☐	☐	☐	
Harrassment/Stalking	☐	☐	☐	
Photo/Video	☐	☐	☐	

Pertinent Information Related to Assault

Patient use of alcohol ☐Yes ☐No ☐Attempted ☐Unsure

Patient lapse of consciousness ☐Yes ☐No ☐Attempted ☐Unsure

Did patient injure perpetrator? ☐Yes ☐No ☐Attempted ☐Unsure

The Assailant ... ☐Wore gloves ☐Wore mask ☐Washed self ☐Washed patient ☐Cleaned scene

Describe any indicated above:

Post-Assault Hygiene

☐None ☐Showered ☐Bathed ☐Ate/Drank ☐Urinated ☐Defecated ☐Vomited ☐Used mouthwash ☐Brushed teeth ☐Rinsed mouth ☐Changed clothes ☐Smoked

Post-Sexual Assault Only:

☐Wiped/Washed Genitals ☐Removed/inserted: Pad/Tampon/Menstrual cup/Other _____

Describe any indicated above:

Post-Assault Symptoms

☐None ☐Memory loss ☐Abdominal/Pelvic pain ☐Constipation ☐Nausea ☐Vomiting ☐Loss of consciousness ☐Other _____

Post-Sexual Assault Anogenital Symptoms: ☐Pain with urination ☐Anal/Rectal itching ☐Anal/Rectal pain ☐Anal/Rectal bleeding ☐Genital itching ☐Genital pain ☐Genital bleeding ☐Genital discharge

Describe any indicated above:

Sexual Assault – Acts Involved:

Penetration to Female Sex Organ

Penis ☐Yes ☐No ☐Attempted ☐Unsure
Finger ☐Yes ☐No ☐Attempted ☐Unsure
Object ☐Yes ☐No ☐Attempted ☐Unsure

Penetration to Anus

Penis ☐Yes ☐No ☐Attempted ☐Unsure
Finger ☐Yes ☐No ☐Attempted ☐Unsure
Object ☐Yes ☐No ☐Attempted ☐Unsure

Oral Contact to Genitals

Offender to Patient ☐Yes ☐No ☐Attempted ☐Unsure
Patient to Offender ☐Yes ☐No ☐Attempted ☐Unsure

Oral Contact to Anus

Offender to Patient ☐Yes ☐No ☐Attempted ☐Unsure
Patient to Offender ☐Yes ☐No ☐Attempted ☐Unsure

Ejaculation of Assailant ☐Yes ☐No ☐Attempted ☐Unsure
(If yes, where discarded: _____)

Contraceptive or Lubricant Products

Condom ☐Yes ☐No ☐Attempted ☐Unsure
(If yes, where discarded: _____)
Lubrication ☐Yes ☐No ☐Attempted ☐Unsure
Jelly ☐Yes ☐No ☐Attempted ☐Unsure
Foam ☐Yes ☐No ☐Attempted ☐Unsure

Non-Genital Acts

Kissing ☐Yes ☐No ☐Attempted ☐Unsure
Licking ☐Yes ☐No ☐Attempted ☐Unsure
Biting ☐Yes ☐No ☐Attempted ☐Unsure
Suction Injury ☐Yes ☐No ☐Attempted ☐Unsure

Consensual Intercourse in the Past Five Days: ☐None ☐Vaginal ☐Oral ☐Anal

J. REVIEW OF SYSTEMS

Constitutional
☐Fever
☐Chills
☐Profuse sweating
☐Fatigue, lethargy, malaise
☐Other _____
☐Not reviewed

Eyes
☐Eye disease, injury or surgery
☐Vision changes
☐Pain or irritation
☐Other _____
☐Not reviewed

Ears, Nose, Mouth, Throat
☐Hearing loss, ringing in ears
☐Ear pain or discharge
☐Nosebleeds
☐Sinus/allergy problems
☐Difficulty swallowing
☐Other _____
☐Not reviewed

Respiratory
☐Cough
☐Shortness of breath
☐Wheezing
☐Asthma, disease
☐Other _____
☐Not reviewed

Cardiovascular
☐Chest pain
☐Swelling
☐Irregular heartbeat, palpitations
☐Shortness of breath with exertion
☐Other _____
☐Not reviewed

Gastrointestinal
☐Difficulty swallowing
☐Nausea/vomiting
☐Abdominal pain
☐Diarrhea/constipation
☐Blood in stool
☐Heartburn/reflux
☐Other _____
☐Not reviewed

Genitourinary
☐Frequent or painful urination
☐Urinary incontinence
☐Blood in urine
☐Urinary urgency
☐Other _____
☐Not reviewed

Female Reproductive
☐Breast concerns
☐Vaginal discharge
☐Painful intercourse
☐Problems with sexual function
☐Other _____
☐Not reviewed

Male Reproductive
☐Problems with sexual function
☐Testicular pain/lump
☐Penile discharge
☐Other _____
☐Not reviewed

Musculoskeletal
☐Joint pain, stiffness, swelling
☐Muscle pain, weakness, cramping
☐Decreased range of motion
☐Chronic pain Location _____
☐Other _____
☐Not reviewed

Neurological
☐Headaches
☐Numbness
☐Balance problems, dizziness
☐Confusion, memory loss
☐Seizures
☐Tremor
☐Other _____
☐Not reviewed

Endocrine
☐Heat or cold intolerance
☐Weight loss/gain
☐Appetite changes
☐Frequent thirst
☐Other _____
☐Not reviewed

Hematology-Oncology-Lymphatic
☐History of disease
☐Anemia
☐Swollen/tender lymph nodes
☐Bruises easily
☐History of tranfusion
☐Recurring infections
☐Other _____
☐Not reviewed

Infectious Disease
☐Exposure to infectious disease
☐Other _____
☐Not reviewed

Skin/Hair
☐Rashes or sores
☐Suspicious moles or lesions
☐Hair loss
☐Other _____
☐Not reviewed

Mental Health
☐History of depression, anxiety or mental illness
☐Sleep problems
☐Substance use disorder
☐Suicidal/homicidal ideation
☐Other _____
☐Not reviewed

K. PHYSICAL EXAMINATION

Exam Time: Start _____ End _____ Height: _____ Weight: _____

Vital Signs BP: _____ HR: _____ Resp: _____ Temp: _____

Head/Face/Mouth/Neck:	☐No injury noted	☐Pertinent Findings	☐See Body Map
Chest/Breasts:	☐No injury noted	☐Pertinent Findings	☐See Body Map
Abdomen/Pelvis:	☐No injury noted	☐Pertinent Findings	☐See Body Map
Upper Extremities/Hands:	☐No injury noted	☐Pertinent Findings	☐See Body Map
Lower Extremities/Feet:	☐No injury noted	☐Pertinent Findings	☐See Body Map
Back/Buttocks:	☐No injury noted	☐Pertinent Findings	☐See Body Map
Genitals/Anus:	☐No injury noted	☐Pertinent Findings	☐See Body Map

Describe any indicated above:

Laboratory Testing:

- ☐Serology
- ☐STD testing
- ☐Blood alcohol
- ☐DFSA
- ☐Other:_____

Examination Techniques Used for Genital/Anal Exam:

- ☐Direct visualization
- ☐Foley
- ☐Speculum
- ☐TB dye
- ☐Labial traction
- ☐Labial separation
- ☐Moist swab
- ☐Other:_____

Examination Positions Used for Genital/Anal Exam:

- ☐Supine lithotomy
- ☐Supine Knee to Chest
- ☐Other:_____

Alternative Light Source

Used on body: ☐Yes ☐No **Findings:**_____

Used on clothing: ☐Yes ☐No **Findings:**_____

Please see hospital medical record for additional laboratory, imaging and diagostic orders and results.

L. SPECIMEN COLLECTION SUMMARY

Specimens Obtained		Notes:
Buccal-DNA Standard	☐	
Oral	☐	
Peri-oral/lips	☐	
Head Hair Combing	☐	
Fingernails: ☐Swabs ☐Scrapings	☐	
Hands: ☐Left ☐Right ☐Bilateral	☐	
Neck: ☐Left ☐Right ☐Bilateral	☐	
Breasts: ☐Left ☐Right ☐Bilateral	☐	
Inner Thigh: ☐Left ☐Right ☐Bilateral	☐	
Abdomen	☐	
Pubic Hair Combing	☐	
External Female Sex Organ	☐	
Internal Female Sex Organ	☐	
Male Sex Organ: ☐Penile ☐Scrotal	☐	
Anal Folds	☐	
Anal Canal	☐	
Perineum	☐	
Intergluteal cleft	☐	
Sacrum/Lower back	☐	
Vaginal	☐	
Cervical	☐	
Speculum	☐	
☐Pantyliner ☐Tampon	☐	
Underwear Worn During Assault	☐	
Underwear Worn to Exam (not during assault)	☐	
Soil/Debris	☐	
Internal Foreign Body: ☐Vaginal ☐Anal	☐	
Diaper	☐	
Other:_____	☐	
Other:_____	☐	

Photodocumentation Obtained

☐Body ☐Genitals ☐Clothing ☐None

☐Other_____

Persons Present During Specimen Collection

Name	*Relationship to Patient*

Clothing Collected

Underwear must be placed into the Sexual Assault Evidence Collection Kit

Item	*Description*

Total Number of Brown Bags: _____

Please ensure that ALL items are submitted to law enforcement with the Sexual Assault Evidence Collection Kit.

Nurse Examiner/Collector Information

Printed Name: _____

Signature: _____

Credentials: _____

Date/time of Specimen Collection: _____

M. STRANGULATION/SUFFOCATION ASSESSMENT ☐ Not Applicable

Method(s)	Right	Left	Both	Unknown
☐Hand(s)	☐	☐	☐	☐
☐Foot	☐	☐	☐	☐
☐Knee	☐	☐	☐	☐
☐Forearm	☐	☐	☐	☐
☐Ligature List item used, if known:				
☐Smothered List item used, if known:				
☐Suffocated (i.e., covering nose or mouth) If yes, how:				
☐Shaken				
☐Head Struck Against: ☐Wall ☐Floor ☐Ground ☐Unknown				
☐Restricted Torso (ie., sat on chest) Method:				
☐Patient's feet left the ground				
☐Other				

Assailant is:

☐Right Handed ☐Left Handed ☐Unknown

☐Ambidextrous

On a scale of 0-10, how much of the assailant's strength do you think was used during strangulation or suffocation? (0 = no effort; 10 = maxium effort)

_____

Describe the Assailant's Demeanor During the Event

What Did the Assailant Say to You Before, During and After the Strangulation/Suffocation?

What did you think was going to happen to you while you were being strangled/suffocated?

Why did the assailant stop strangling/suffocating you?

What did you see while you were being strangled/suffocated?

What did you smell while you were being strangled/suffocated?

Have you been strangled prior to this event by the same assailant? ☐No ☐Yes

If Yes: How many times before this has the assailant placed pressure on your neck or suffocated you? _____

When was the last time? _____

Signs and Symptoms Reported by Patient Post-Assault

Breathing Changes:

☐Difficulty Breathing ☐Hyperventilation

☐Shortness of Breath ☐Dyspnea ☐Hemoptysis

☐Unable to tolerate supine position ☐Respiratory distress

☐Stridor ☐None

☐Other_____

Voice Changes:

☐Raspy Voice ☐Hoarseness ☐Coughing

☐Frequent throat clearing ☐Inability to speak ☐None

☐Other_____

Swallowing Changes:

☐Difficulty Swallowing ☐Painful to swallow ☐Throat pain

☐Drooling ☐None

☐Other_____

Neurological Changes:

☐Agitation ☐Behavioral changes ☐Memory loss

☐Loss of consciousness ☐Hallucinations ☐Loss of sensation

☐Weakness in extremities ☐Difficulty speaking

☐Loss of bladder control ☐Loss of bowel control ☐Vertigo

☐Syncope/Near Syncope ☐None

☐Other_____

Other:

☐Swelling ☐Pain ☐Vision changes

☐Ringing in ears/Hearing changes

☐Abdominal pain ☐Nausea ☐Vomiting ☐None

Examination Findings

Head/Scalp:
☐Abrasions ☐Bald Spots/Missing Hair ☐Bruising
☐Lacerations ☐Petechiae ☐None
☐Other_____
Describe Findings:

Face:
☐Petechiae ☐Abrasions ☐Lacerations ☐Swelling
☐Facial Drooping ☐Redness ☐Discoloration ☐None
☐Other_____
Describe Findings:

Eyes:
☐Petechiae ☐Subconjunctival hemorrhage ☐Bleeding
☐Droopy eyelids ☐Lacerations ☐Discoloration ☐None
☐Other_____
Describe Findings:

Nose:
☐Bleeding ☐Deformity ☐Petechiae ☐Swelling ☐None
☐Other_____
Describe Findings:

Ears:
☐Petechiae ☐Swelling ☐Bruising behind ears
☐Bleeding - external ☐Bleeding from ear canal ☐None
☐Other_____
Describe Findings:

Mouth:
☐Bruising ☐Swollen tongue ☐Abrasions ☐Swelling
☐Lacerations ☐Petechiae in mouth ☐Drooling
☐Torn frenulum ☐Broken teeth ☐Discoloration ☐None
☐Other_____
Describe Findings:

Under Chin:
☐Abrasions ☐Bruising ☐Petechiae ☐Redness
☐Swelling ☐None
☐Other_____
Describe Findings:

Neck:
☐Petechiae ☐Redness ☐Abrasions
☐Fingernail impressions ☐Lacerations ☐Bruising
☐Swelling ☐Ligature marks ☐Patterned injury ☐None
☐Other_____
Describe Findings:

Chest:
☐Bruising ☐Redness ☐Abrasions ☐Swelling ☐Lacerations
☐Abnormal breath sounds ☐None
☐Other_____
Describe Findings:

Photodocumentation: ☐Yes ☐No

Nurse Examiner Information

Printed Name: _____

Signature: _____

Credentials: _____

Date/time: _____

Body Maps

Using legend below, document findings of exam on body diagrams (use all that apply):				
AB Abrasion	**BI** Bite Mark	**BR** Bruise	**BU** Burn	**DF** Deformity
ER Erythema	**FB** Foreign Body	**IW** Incised Wound	**LA** Laceration	**PT** Petechiae
RE Redness	**SI** Suction Injury	**SW** Swelling	**TE** Tenderness	
OI Other Injury (describe):_____				

Diagram A

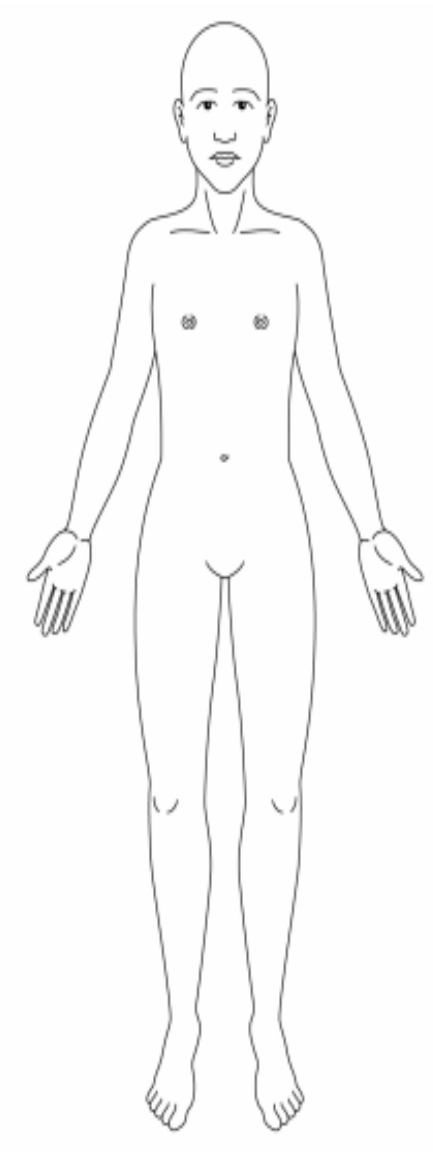


Diagram B

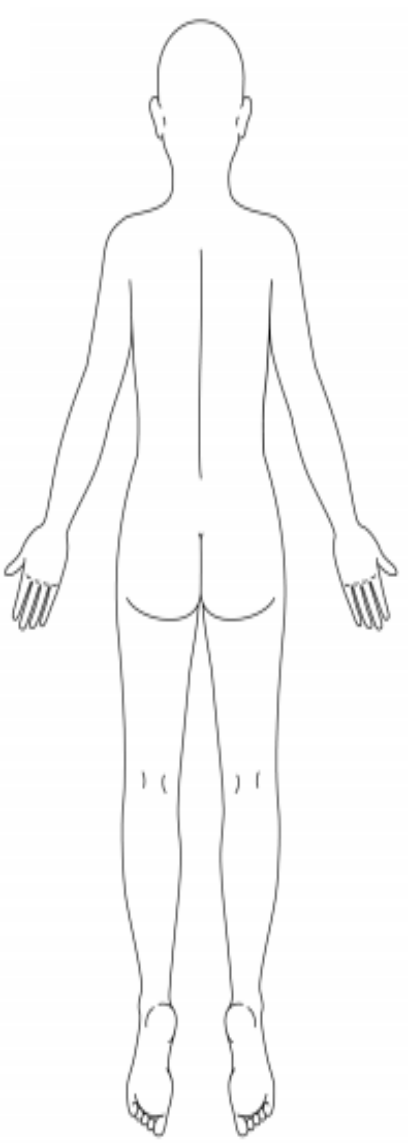
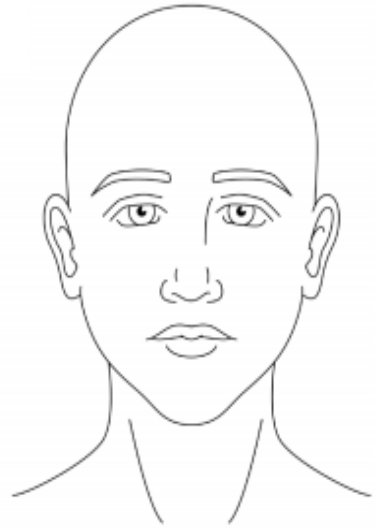


Diagram	Number	Type	Description	Photo #s

Forensic Nurse Initials _____

Diagram C



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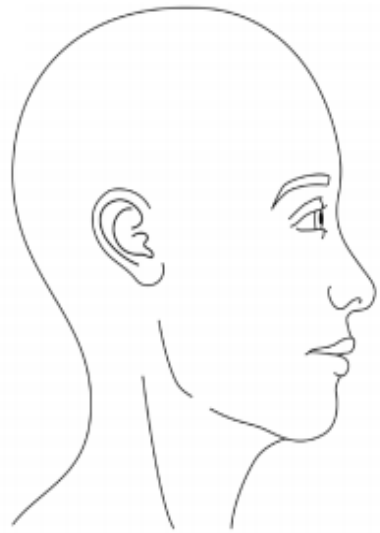

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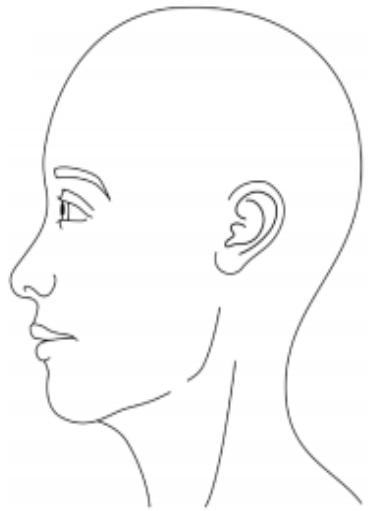


Diagram F

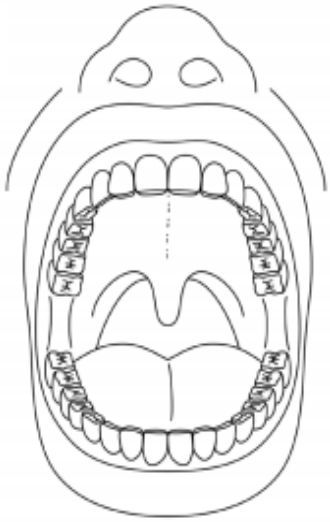
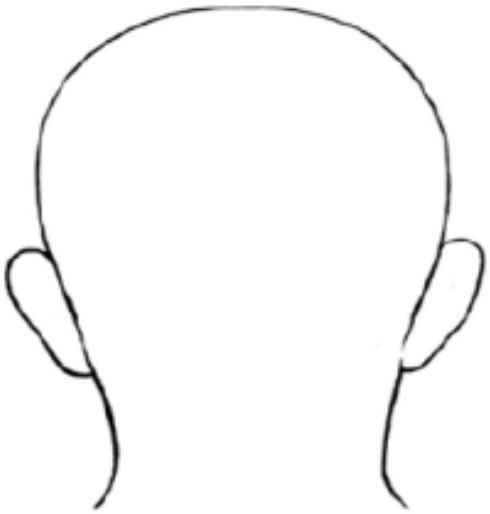


Diagram	Number	Type	Description	Photo #s

Forensic Nurse Initials _____

Diagram G



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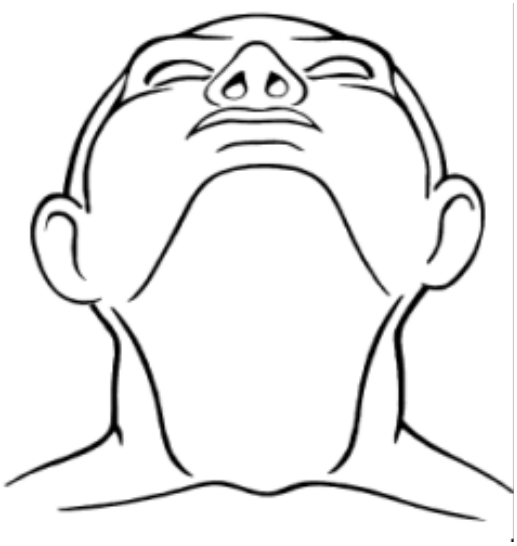


Diagram I

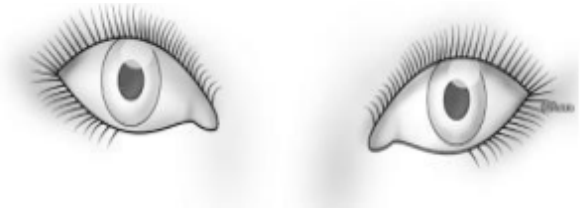
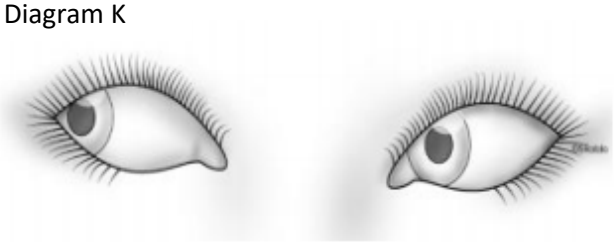


Diagram J

Diagram K



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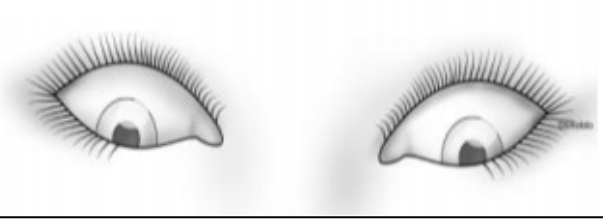

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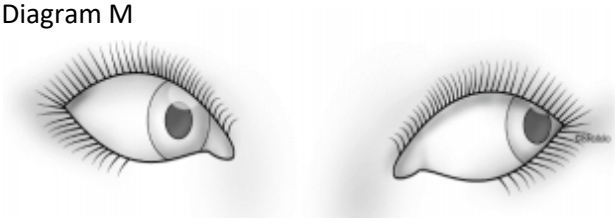

Diagram	Number	Type	Description	Photo #s

Forensic Nurse Initials _____

Diagram N

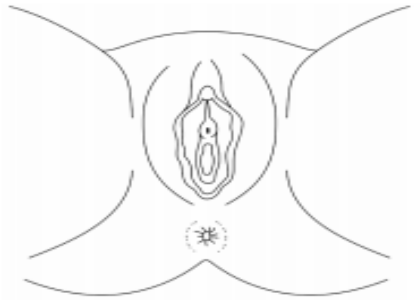

Diagram O

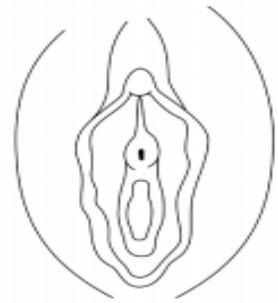

Diagram P

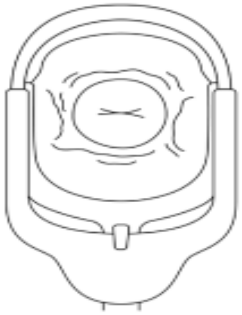

Diagram Q

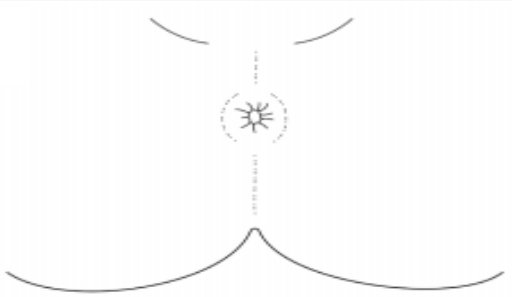

Diagram	Number	Type	Description	Photo #s

Forensic Nurse Initials _____

Diagram R

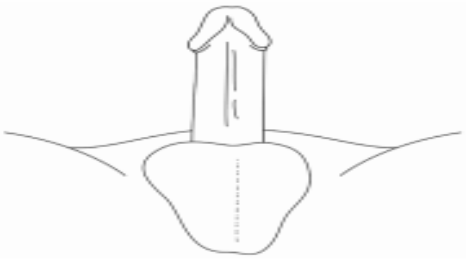

Diagram S

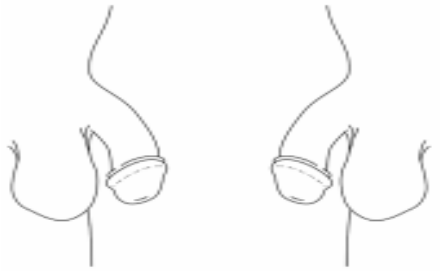

Diagram T

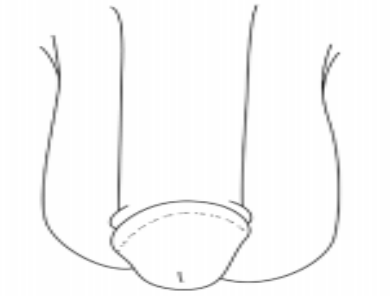

Diagram U

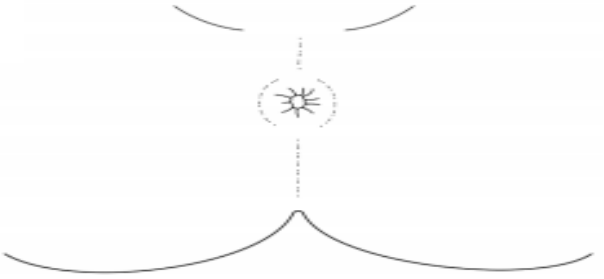

Diagram	Number	Type	Description	Photo #s

Forensic Nurse Initials _____

CHAIN OF CUSTODY FORM

Patient Label:
(if anonymous, use MRN only)

MRN _____

[Place patient label here]

Date of Service: _____

Items Collected: ☐ Sexual Assault Evidence Collection Kit ☐ Clothing
☐ Other: _____

Total number of brown bags: _____

Collector's Name/Initials: _____

Date and time of evidence collection: _____

DATE/TIME	RELINQUISHED BY:	RECEIVED BY:
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____