PEDIATRIC
MEDICAL FORENSIC EXAMINATION RECORD
Confidential Document

Patient Identification

Name of Medical Facility:

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:

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

Law Enforcement Agency **Case Number**

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

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

PATIENT HISTORY OF EVENT(S) **Name of person providing history/relationship to patient:**

☐See attached narrative

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
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**	

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) _____

SOCIAL HISTORY

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 _____

SEXUAL ORIENTATION / GENDER IDENTITY

How Does the Patient Identify? ☐Boy ☐Girl ☐Other_____

PEDIATRIC CAREGIVER ASSESSMENT

Name of Caregiver	Relationship to Child

Names and Ages of All Persons Living in the Home

Why is Child Being Seen Today?

Are There Any of the Following on the Child's Genital/Anal Area?

☐Cream ☐Ointment ☐Powder ☐Medication ☐Other:

Does the Child Currently or Recently Wear Diapers?

☐No ☐Yes **If Yes:** ☐Cloth ☐Disposable

	No	Yes	If Yes, Explain
Does the Child Experience Repeated Rash or Infection to Diaper Area?	☐	☐	
Does the Child Wear Nylon Panties or Leotards?	☐	☐	
Are There Recent Sores or Rashes in Genital/Anal Area?	☐	☐	
Is There Bruising to Private Parts, Inner Thighs or Buttocks?	☐	☐	
Does Child Have Pain/Burning with Urination?	☐	☐	
Does the Child Accidentally Wet Underwear Past Potty Training?	☐	☐	
Does the Child Wet the Bed?	☐	☐	When Did This Start?
Does the Child Have Bowel (BM or Soiling) Accidents in Pants?	☐	☐	
Has the Child Had Repeated Constipation?	☐	☐	
Has the Child Had Repeated Diarrhea?	☐	☐	
Has the Child Been Given Rectal Suppositories?	☐	☐	When and Why?
Has the Child Been Given Enemas?	☐	☐	When and Why?
Has the Child Had Blood in Underwear?	☐	☐	
Has the Child Had Discharge or Drainage in Underwear?	☐	☐	State Color and Odor:
Has the Child Had Repeated Itching or Scratching to Private Area (Genital or Anal)?	☐	☐	

	No	Yes	If Yes, Explain
Does the Child Have Difficulty Walking or Sitting Because of Pain or Itching in the Private Area?	☐	☐	
Have You Ever Been Informed by a Doctor that Your Child Has Any Genital or Anal Abnormalities?	☐	☐	
Has Child Recently Experienced Repeated Episodes of Vomiting?	☐	☐	
Does Mother Have History of Sexually Transmitted Infections?	☐	☐	☐Prior to Pregnancy or ☐During Pregnancy
Does Father Have History of Sexually Transmitted Infections?	☐	☐	
Are there Other Caregivers with a History of Sexually Transmitted Infections?	☐	☐	
Has Child Recently Experienced a Minor Illness (i.e., Cough, Cold, Ear Infection, Strep Throat, RSV, Flu, Covid-19)?	☐	☐	

BATHING/HYGIENE

Does the Child Take Showers or Baths? ☐Shower ☐Bath ☐Both

	No	Yes	If Yes, Explain
Does the Child Ever Take Bubble Baths?	☐	☐	**How Often?**
Does the Child Ever Bathe with Other Children? If Yes, Who?	☐	☐	
Does the Child Ever Bathe with Adults? If Yes, Who?	☐	☐	
Does the Child Require Assistance with Bathing? If Yes, Who?	☐	☐	
Has Anyone Noticed Any Sudden Changes in the Child's Bathing Habits?	☐	☐	

HEALTH HISTORY

Child Born: ☐Early ☐On Time ☐Late

Child's Birth Weight: _____

	No	Yes	If Yes, Explain
Were there Problems at Birth?	☐	☐	
Has the Child Stayed Overnight in the Hospital?	☐	☐	
Does the Child Complain of Pain Now?	☐	☐	
Has the Child Ever Had an Examination of the Private Parts?	☐	☐	

What Words Does the Child Use for the Following Body Parts?

☐Penis_____ ☐Breasts_____ ☐Vagina/Vulva_____ ☐Anus_____

Has the Child Experienced Any of the Following?

☐Problems with vision ☐Problems with speech ☐Bleeding/Bruising problems ☐Asthma
☐Problems with moving or walking ☐Bladder/Urinary tract infections ☐Stitches
☐Seizures/Convulsions ☐Broken bones/Bone disorders ☐Seasonal allergies ☐Ear infections
☐Yeast infections ☐Sexually transmitted infections ☐Operations/Surgeries

If Selected, Explain:

DEVELOPMENT			
	No	Yes	If Yes, Explain
Do You Feel that the Child Does Not Walk, Talk and Behave Like Other Children of the Same Age?	☐	☐	
Does the Child Attend School?	☐	☐	School and Grade Level:
Does the Child Experience Any Problems in School?	☐	☐	
Does the Child Attend Any Special Education Classes or Require an Individualized Education Plan (IEP)?	☐	☐	
Has Anyone Noticed Any Changes in School Behavior (i.e., Skipping School, Stopped Participating, Problems with Friends, etc.)?	☐	☐	
Does the Child Experience Stress-Related Behaviors (i.e., Nail Biting, Clinging, Frequent Stomachaches, etc.)?	☐	☐	
Has Anyone in the Family Received Services from the Department of Child Services or Ever Been Removed from the Home?	☐	☐	

PATIENT'S PRESENTATION

General Physical Appearance

Condition of Clothing

Demeanor of Patient

ASSAULT HISTORY

Approximate 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

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: _____)

Non-Genital Acts

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

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

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

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

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.

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: _____

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, smell, taste, hear and feel while you were being strangled/suffocated?

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

I**f Yes:** Approximately how many times before 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

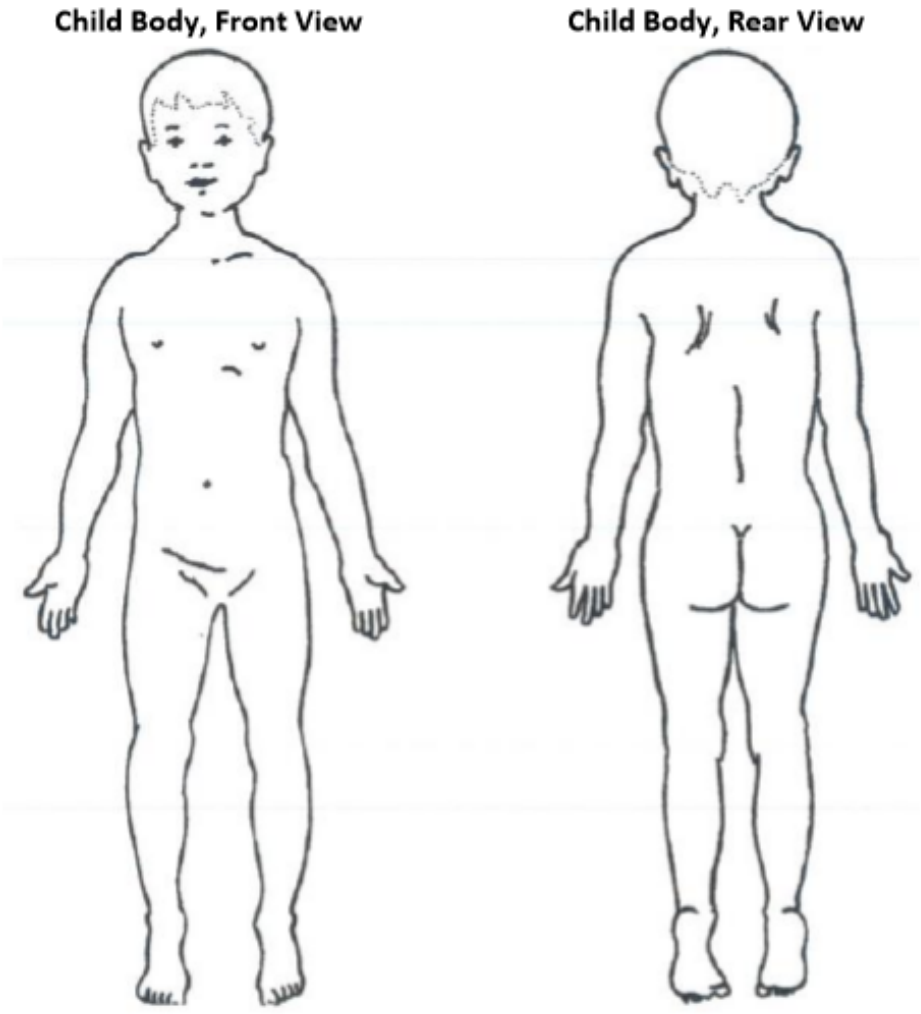

Diagram	Number	Type	Description	Photo #s

Forensic Nurse Initials _____

Diagram B

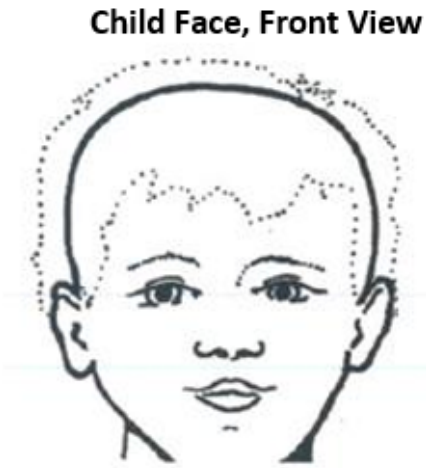

Diagram C

Diagram D

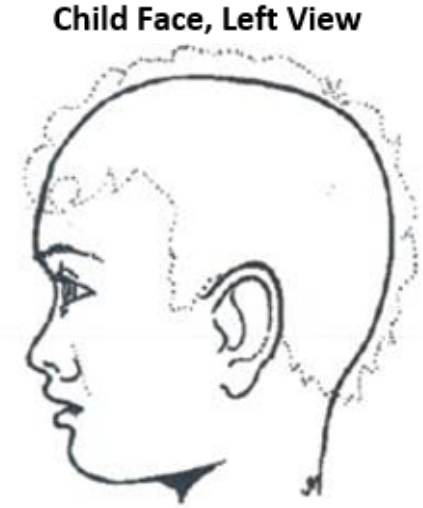

Diagram E

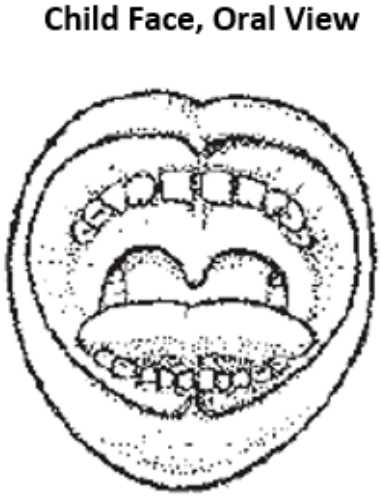

Diagram	Number	Type	Description	Photo #s

Forensic Nurse Initials _____

Diagram F

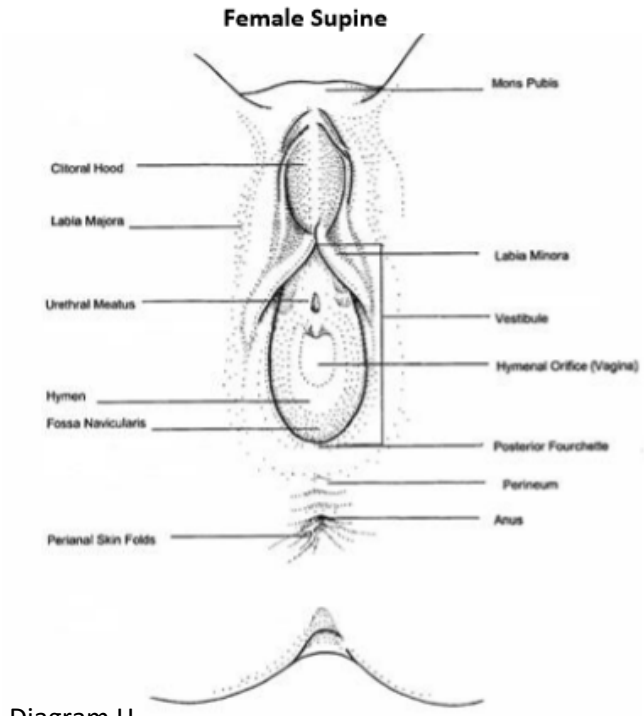

Diagram G

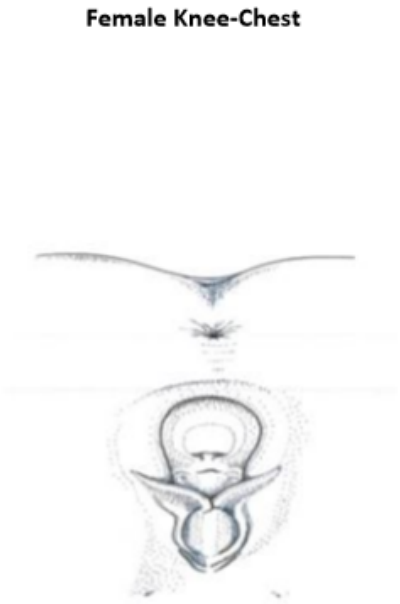

Diagram H

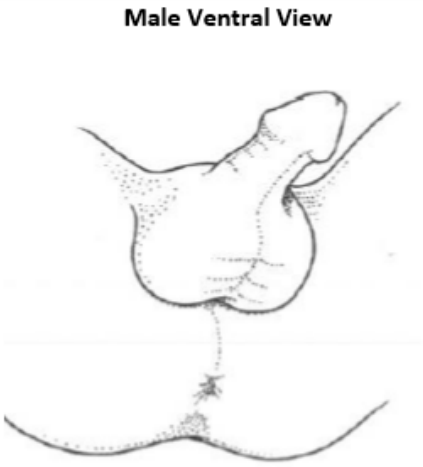

Diagram I

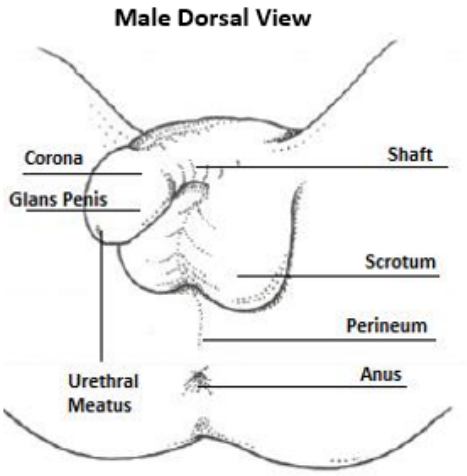

Diagram	Number	Type	Description	Photo #s

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: _____