

Pelvic Exam

01	Date of pelvic exam:	___ / ___ / _____ (dd/mm/yyyy)
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! The following Film Assessment questions are only applicable at V6, V9 and Interim Visits requiring a pelvic exam. Skip to Question 03 below if this visit is taking place prior to the insertion of film #1.

02	Is the film visible?	<input type="checkbox"/> Yes (answer 02a) <input type="checkbox"/> No <input type="checkbox"/> Unsure
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! 02a. Complete only if the film is visible:

Was film removed prior to specimen collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Narrative related to film visibility and removal:	

03	Bleeding on exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No
04	External Genital Exam:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (answer 04a) <input type="checkbox"/> Not done

! 04a. Complete only if abnormal External Genital Exam:

<input type="checkbox"/> Edema <input type="checkbox"/> Erythema <input type="checkbox"/> Ulcer <input type="checkbox"/> Blister <input type="checkbox"/> Pustule <input type="checkbox"/> Genital warts <input type="checkbox"/> Other (specify): _____
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05	Internal Genital Exam:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (answer 05a) <input type="checkbox"/> Not done
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! 05a. Complete only if abnormal Internal Genital Exam:

<input type="checkbox"/> Edema <input type="checkbox"/> Erythema <input type="checkbox"/> Laceration <input type="checkbox"/> Ulcer <input type="checkbox"/> Blister <input type="checkbox"/> Pustule <input type="checkbox"/> Other (specify): _____

Pelvic Exam (continued)

06	Cervical Exam:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (answer 06a) <input type="checkbox"/> Not done
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! 06a. Complete only if abnormal Cervical Exam:

- Edema/friability
- Erythema
- Discharge
- Ulcer
- Blister
- Pustule
- Other (specify): _____

07	Was a vaginal pH done?	<input type="checkbox"/> Yes (answer 07a) <input type="checkbox"/> No
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! Required at V9 Week 8 Clinic Follow-up visit.

! 07a. Complete only if vaginal pH done:

Date of vaginal pH collection:	___ / ___ / ____ (dd/mm/yyyy)
Vaginal pH:	_____

08	Was vaginal wet prep done?	<input type="checkbox"/> Yes (answer 08a) <input type="checkbox"/> No
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! Only required if indicated, and/or per local standard of care.

! 08a. Complete only if vaginal wet prep done:

Wet prep result:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (answer 08b)
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! 08b. Complete only if abnormal vaginal wet prep:

Wet prep result:	<input type="checkbox"/> Buds/hyphae <input type="checkbox"/> >20% clue cells <input type="checkbox"/> Motile trich
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09	Notes/Comments:
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CRF Completed By: _____ (initials)

CRF Completion Date: ___ / ___ / ____ (dd/mm/yyyy)