

Gu Physical Exam Documentation

Gu Physical Exam Documentation: A Detailed Guide for Clinicians **gu physical exam documentation** plays a crucial role in the clinical evaluation of patients presenting with genitourinary complaints. Whether you are a medical student, resident, or experienced clinician, understanding how to properly document findings during a genitourinary (GU) physical exam is essential. Not only does accurate documentation support clinical decision-making, but it also ensures clear communication among healthcare providers and serves as a legal record of patient care. In this article, we will explore the key components of gu physical exam documentation, offer practical tips for effective note-taking, and highlight important considerations that can improve both patient outcomes and workflow efficiency.

Understanding the Importance of GU Physical Exam Documentation

The genitourinary system encompasses organs involved in urinary function and reproduction, including the kidneys, ureters, bladder, urethra, and reproductive organs such as the

testes, prostate, and vagina. When patients present with symptoms like dysuria, hematuria, pelvic pain, or erectile dysfunction, a thorough GU physical exam is indispensable. Documenting the exam accurately helps to:

1. Track changes over time and monitor disease progression
2. Provide evidence for treatment decisions and referrals
3. Facilitate billing and coding based on exam complexity
4. Support medico-legal documentation and compliance

Key Elements to Include in GU Physical Exam Documentation

When writing a GU physical exam note, clarity and completeness are paramount. Here are the primary components that should be addressed:

1. Inspection

Begin with a detailed visual assessment of the external genitalia. Note any abnormalities such as swelling, erythema, lesions, ulcers, or discharge. For example, in males, document the appearance of the penis, scrotum, and perineum. In females, describe the vulva, labia, and surrounding areas. Example phrasing: “No erythema or edema noted on the scrotum. No visible lesions or discharge from the urethral meatus.”

2. Palpation

Palpation is critical for detecting masses, tenderness, or irregularities. In males, palpate the testes, epididymis, and spermatic cord. Check the prostate via digital rectal exam (DRE) when indicated, noting size, consistency, and tenderness. In females, palpate the inguinal lymph nodes and pelvic organs during a bimanual exam. Example: “Testes are symmetric, non-tender, and without masses. Prostate is smooth, approximately 20 grams, without nodules or tenderness.”

3. Functional Assessment

In some cases, assessment of urinary stream, post-void residual volume, or erectile function may be relevant. While these are often gathered via history or specialized testing, documenting any bedside assessments performed adds value.

4. Additional Findings

Include observations regarding lymphadenopathy, hernias, or signs of systemic illness related to GU pathology. For example, inguinal lymph node enlargement may indicate infection or malignancy.

Tips for Effective GU Physical Exam Documentation

Good documentation balances thoroughness with efficiency, avoiding overly verbose notes while capturing all clinically relevant information.

Use Standardized Terminology

Employ medical terms that are universally understood among healthcare professionals. Terms like “erythematous,” “indurated,” or “fluctuant” convey precise findings and reduce ambiguity.

Be Objective and Specific

Avoid vague descriptors such as “normal” or “unremarkable” without specifying what was examined. Instead of “normal genital exam,” write “penis and scrotum without lesions, masses, or discharge.”

Document Negative Findings

Noting the absence of symptoms or signs—such as “no inguinal lymphadenopathy” or “no scrotal tenderness”—is just as important as positive findings, as it helps rule out differential diagnoses.

Incorporate Relevant Patient History

While the focus is on physical exam findings, referencing pertinent history can provide context for the documented findings. For example, if a patient reports testicular pain, documenting the exam focused on tenderness or swelling is essential.

Common Challenges in GU Physical Exam Documentation and How to Overcome Them

Even seasoned clinicians sometimes struggle with GU exam notes. Here are some common hurdles and strategies to address them:

1. Sensitivity and Patient Comfort

The genitourinary exam can be uncomfortable or embarrassing for patients. It's important to document that informed consent was obtained and that the patient's dignity was respected.

Example: "Exam performed with patient consent; efforts made to maintain privacy and comfort throughout."

2. Variability in Exam Techniques

Different providers may perform GU exams with slight

variations. Standardizing documentation templates or checklists can help ensure consistency.

3. Time Constraints

In busy clinical settings, time may be limited. Utilizing electronic health record (EHR) templates with dropdown menus or pre-populated fields for GU exam findings can streamline note-writing.

Integrating GU Physical Exam Documentation into Electronic Health Records

With the widespread adoption of EHR systems, documenting the GU exam digitally has become the norm. Leveraging EHR functionality can improve accuracy and save time.

1. **Templates:** Many EHRs offer genitourinary exam templates that prompt clinicians to enter specific findings systematically.
2. **Voice Recognition:** Dictation tools allow for natural language entry of exam notes, which can then be edited for precision.
3. **Photographic Documentation:** In select cases, images of lesions or abnormalities (with patient consent) can be incorporated into the record.

Using these tools effectively ensures that gu physical exam documentation is both comprehensive and easily retrievable for future reference.

Legal and Ethical Considerations in GU Physical Exam Documentation

Because of the sensitive nature of the genitourinary exam, clinicians must be mindful of privacy laws and ethical standards. Thorough documentation protects both the patient and provider by:

1. Confirming that informed consent was obtained before the exam
2. Recording the presence of chaperones during the exam when applicable
3. Describing the exam in a professional, respectful manner
4. Maintaining confidentiality of the records

These measures help maintain trust and reduce the risk of misunderstandings or legal disputes.

Enhancing Clinical Decision-Making Through Detailed GU Exam Notes

High-quality gu physical exam documentation is more than a bureaucratic necessity—it can directly influence patient care

decisions. For example, noting prostate enlargement or nodularity may prompt further diagnostic testing such as PSA measurement, imaging, or biopsy. Similarly, identifying testicular masses or asymmetry can lead to urgent referrals to urology. In emergency settings, documenting findings like scrotal tenderness, swelling, or erythema can expedite diagnosis of testicular torsion, which requires immediate intervention.

Conclusion: Mastering GU Physical Exam Documentation

Incorporating precise and thorough gu physical exam documentation into clinical practice enhances communication, supports patient care, and ensures medico-legal protection. By focusing on detailed inspection, palpation, and functional assessments, and by leveraging modern documentation tools, clinicians can create notes that are both informative and efficient. Remember, quality documentation reflects quality care—especially when it comes to sensitive exams like those of the genitourinary system.

In 2026, the landscape of patient care documentation is shifting rapidly, driven by technological integration and heightened regulatory demands. At the core of this evolution lies the crucial topic of **gu physical exam documentation**—a foundational element that ensures continuity, legal protection, and optimal

clinical outcomes. As healthcare organizations face increasing scrutiny around documentation accuracy and accessibility, understanding the nuances of this process becomes essential.

Understanding the Essentials of Gu Physical

Gu physical exam documentation refers to the structured, comprehensive recording of patient assessments during a clinical evaluation. This documentation encompasses vital signs, physical findings, patient history notes, and diagnostic impressions as gathered during the examination. Its importance transcends individual records; it supports care coordination, informs treatment plans, and strengthens patient trust.

Why Accurate Gu Physical Exam Documentation

Inaccuracies or omissions in these records can lead to misdiagnosis, delayed interventions, and compromised patient safety. Studies from 2025 indicate that 34% of medical errors stem from incomplete or incorrect documentation—highlighting how vital proper **gu physical exam documentation** is to clinical reliability. Moreover, electronic health records (EHR) now connect every patient interaction, making thorough and timely entries critical.

Accurate documentation also plays a significant role in legal contexts. When medical disputes arise, well-documented physical exams are often the most compelling evidence. A 2023 survey found that 82% of healthcare providers view detailed **gu physical exam documentation** as a key defense against malpractice claims.

Key Components of Effective Gu Physical

To build robust documentation, healthcare teams must adhere to standardized structures. Key elements include:

1. **Standardized Forms and Templates:** Use of uniform templates ensures all necessary data points are captured systematically.
2. **Timeliness:** Documenting findings immediately after the exam reduces recall bias and mistakes.
3. **Patient-Centered Language:** Using clear, specific terminology avoids ambiguity and enhances comprehension.
4. **Integration with EHR Systems:** Automated fields and real-time updates minimize manual errors.

These components not only streamline workflows but also improve interoperability when sharing records across systems—a necessity in today's connected healthcare environment.

The Role of Technology in Enhancing

Artificial intelligence (AI) and machine learning are revolutionizing how **gu physical exam documentation** is created and maintained. AI-driven tools can analyze exam findings, suggest relevant tests, and flag inconsistencies—acting as an intelligent assistant for clinicians.

For example, voice-to-text software allows doctors to document during exams without pausing, reducing transcription delays. Natural language processing (NLP) helps in auto-populating structured data fields, ensuring completeness. According to a 2026 report from Healthcare Tech Today, clinics leveraging these technologies reduce documentation time by 25% while improving accuracy by 18%.

Wearable devices and IoT sensors are also feeding real-time biometrics directly into EHRs, enriching the physical exam with continuous monitoring data. This reduces reliance on retrospective reports and enhances the depth of assessment.

Regulatory and Compliance Considerations

Documentation is governed by strict regulations like HIPAA in the US and GDPR in Europe, which demand security, privacy, and auditability. Healthcare providers must ensure that **gu**

physical exam documentation complies with all applicable standards to avoid penalties and maintain accreditation.

Audit trails in EHR systems track who accessed or modified records, creating accountability. The Centers for Medicare & Medicaid Services (CMS) recently updated guidelines emphasizing real-time documentation verification, further solidifying the need for immediate and precise entries.

Best Practices for Healthcare Professionals

Adopting best practices requires both training and culture change. Staff should participate in regular workshops focused on documentation standards. Institutions must prioritize usability—complex interfaces discourage thorough entries. Feedback loops, where documentation quality is assessed and discussed, foster continuous improvement.

Training and Ongoing Education

Well-structured training ensures staff understand both clinical and administrative expectations. Role-playing common documentation scenarios (e.g., follow-up exams, emergency assessments) helps reinforce skills. Online modules with interactive simulations are particularly effective—research shows 40% higher retention rates.

Optimizing for EHR Integration

Facilitating smooth EHR integration minimizes redundancy. Customizing templates to match local protocols and embedding decision support (e.g., clinical guidelines) within documentation fields enhances precision. Ensuring mobile compatibility also means documentation is efficient regardless of location.

Challenges and Solutions in Documentation Processes

Despite advancements, challenges persist. Burnout drives rushed entries, while fragmented systems lead to duplicate or conflicting notes. Over-reliance on templates may result in templated, impersonal reports lacking clinical nuance.

Solutions include:

1. Implementing AI-powered suggestions that adapt to clinician style while ensuring compliance.
2. Establishing multidisciplinary documentation teams to review and correct entries collaboratively.
3. Adopting unified health information exchanges (HIEs) to eliminate data silos.

Addressing these issues strengthens trust in the documentation process and enhances the value of **gu physical exam documentation**.

Future Trends in Documentation

Looking ahead, predictive analytics will leverage historical physical exams to forecast patient risks. Blockchain technology may secure documentation chains, ensuring tamper-proof records. Natural language generation (NLG) could produce narratives from raw data, making reports more readable.

Another trend is patient-generated documentation—where individuals log symptoms or vitals via apps, enriching clinical context. Ensuring these inputs are securely integrated while maintaining validation protocols will be key.

Impact on Patient Outcomes

High-quality **gu physical exam documentation** directly influences outcomes. A longitudinal study in 2025 linked complete documentation practices to a 19% reduction in 30-day readmissions. Timely updates enable earlier interventions, preventing complications.

Conclusion

The integration of technology, compliance, and best practices transforms **gu physical exam documentation** from a clerical task into a strategic asset. It underpins safety, efficiency, and trust in modern healthcare. As regulations evolve and patient expectations grow, investing in robust documentation systems is no longer optional—it's essential.

Final Thoughts

In a world where data drives decisions, mastering **gu physical exam documentation** ensures providers deliver care that is not only comprehensive but also legally sound and patient-centered. Continuous improvement, supported by AI and interoperability, guarantees this documentation remains at the heart of quality healthcare. By prioritizing accuracy, timeliness, and system integration, organizations uphold standards that save lives and enhance outcomes.

This comprehensive approach to **gu physical exam documentation** demonstrates that human insight paired with innovation creates unrivaled value, positioning healthcare within a safer, more efficient future.

Gu Physical Exam Documentation: A Critical Component of Urological Care **gu physical exam documentation** serves as a fundamental aspect of patient evaluation in urology and related medical fields. Accurate and thorough documentation of the genitourinary (GU) physical exam not only guides diagnostic reasoning and treatment plans but also plays a pivotal role in legal, billing, and continuity of care processes. As healthcare increasingly embraces electronic health records (EHRs) and standardized clinical workflows, understanding the nuances and best practices of GU physical exam documentation becomes essential for clinicians, medical coders, and healthcare administrators alike.

The Role and Importance of GU Physical Exam Documentation

The genitourinary system encompasses the organs involved in urinary excretion and reproductive functions, including the kidneys, bladder, urethra, prostate, testes, and external genitalia. A comprehensive GU physical exam is often performed when patients present with symptoms such as dysuria, hematuria, pelvic pain, erectile dysfunction, or abnormal genital findings. The documentation of this exam provides an objective record of clinical findings that supports diagnosis and treatment decisions. From a clinical perspective, GU physical exam documentation facilitates:

- Effective communication within multidisciplinary teams.
- Baseline comparisons for monitoring disease progression or response to therapy.
- Identification of subtle or incidental findings that may warrant further investigation.

From an administrative standpoint, well-documented GU exams are indispensable for:

- Accurate medical coding and billing, ensuring appropriate reimbursement.
- Legal protection in cases of malpractice claims.
- Compliance with institutional and regulatory standards.

Components of a Thorough GU Physical Exam Documentation

A detailed GU physical exam note typically includes several key

elements, each reflecting a specific anatomical or functional assessment:

1. **Inspection:** Describes visual observations of the external genitalia, perineum, and surrounding areas for abnormalities such as lesions, swelling, rashes, or asymmetry.
2. **Palpation:** Includes assessment of the testes, epididymis, spermatic cords, prostate gland (via digital rectal exam), and abdominal examination to evaluate for masses, tenderness, or induration.
3. **Percussion:** Occasionally used to evaluate bladder distension or detect fluid collections.
4. **Additional maneuvers:** May involve assessment of hernias, varicoceles, or evaluation of urinary stream and post-void residual volume when relevant.

Each of these components should be meticulously recorded with clinical precision, using standardized medical terminology and avoiding ambiguous language.

Best Practices in GU Physical Exam Documentation

High-quality documentation is characterized by clarity, completeness, and relevance. Several best practices help clinicians enhance the utility of their GU physical exam notes:

Use of Structured Templates and Checklists

Many EHR systems now incorporate structured templates for GU exams, prompting clinicians to systematically address every anatomical region and examination maneuver. This reduces the risk of omitting critical information and promotes consistency across providers. For example, a prostate exam template might guide documentation of size, shape, consistency, tenderness, and nodularity, ensuring a thorough assessment.

Incorporating Objective Findings and Avoiding Subjectivity

Descriptive terms should focus on objective findings. Instead of noting “prostate feels abnormal,” documentation should specify “prostate enlarged to approximately 40 grams, firm but non-nodular, non-tender.” Objective measurements or comparisons to normative values enhance the clinical value of the note.

Integration of Patient History and Symptoms

While the GU physical exam is a distinct component, effective documentation often links exam findings to presenting complaints or historical context. For instance, noting tenderness localized to the epididymis in a patient with acute scrotal pain provides meaningful diagnostic insight.

Addressing Privacy and Sensitivity

Given the intimate nature of the GU exam, documentation should be professional, respectful, and mindful of patient confidentiality. Avoid unnecessary details that do not contribute to medical decision-making.

Challenges and Considerations in GU Physical Exam Documentation

Despite its importance, documenting GU exams presents certain challenges:

Variability in Clinical Practice

Differences in clinician experience, patient anatomy, and presenting conditions can lead to significant variability in how GU exams are performed and documented. This variability can impact the reliability of physical findings and their interpretation.

Time Constraints and Documentation Burden

Physicians often face time pressures that may compromise the depth of documentation. While templates and checklists can streamline the process, there remains a balance between thoroughness and efficiency.

Legal and Ethical Implications

Inadequate or ambiguous documentation of GU exams can have medicolegal consequences, particularly in cases involving sexual health, abuse allegations, or forensic evaluations. Precise recording of exam techniques and patient consent is essential.

Technological Advances Influencing GU Physical Exam Documentation

The digital transformation of healthcare has brought innovations that impact how GU physical exams are documented:

Electronic Health Records and Natural Language Processing

Modern EHRs enable not only structured data entry but also the use of voice recognition and natural language processing (NLP) to transcribe and analyze clinical notes. NLP tools can assist in identifying missing information or inconsistencies in GU exam documentation, promoting quality improvement.

Integration of Imaging and Diagnostic Data

Linking physical exam documentation with ultrasound findings, uroflowmetry, or cystoscopy reports enriches the clinical record

and offers a comprehensive view of GU health.

Telemedicine and Remote Assessments

While physical exams pose challenges in virtual care settings, evolving protocols for remote GU assessments and patient self-reporting are influencing documentation practices. Clinicians must clearly note any limitations or adaptations used during telehealth encounters.

Impact of GU Physical Exam Documentation on Patient Outcomes

Thorough documentation is more than an administrative task; it directly affects patient care quality. Accurate GU exam records enable early detection of malignancies, infections, or anatomical abnormalities. For instance, detailed prostate exam notes can guide timely prostate-specific antigen (PSA) testing or biopsy referrals, potentially improving cancer prognosis. Moreover, precise documentation supports multidisciplinary management, especially in complex cases involving nephrology, oncology, or reproductive endocrinology. In summary, GU physical exam documentation remains a cornerstone of effective urological practice. Its meticulous execution and recording underpin clinical decision-making, facilitate communication, and ensure regulatory compliance. As healthcare technology evolves, integrating best practices with innovative tools will further

enhance the quality and utility of GU physical exam documentation, ultimately benefiting both providers and patients.

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Gu Physical Exam Documentation: The Cornerstone of Clinical Precision In contemporary healthcare, gu physical exam documentation has emerged as a non-negotiable element of patient care quality. This meticulous record-keeping system ensures continuity, supports diagnostic accuracy, and aligns with regulatory frameworks like Meaningful Use and CMS mandates. As medical practice evolves toward interdisciplinary collaboration and digital integration, proper documentation transforms raw clinical observations into actionable intelligence.

Understanding the Anatomy of Gu Physical

At its core, gu physical exam documentation synthesizes critical data points—vital signs, anthropometrics, inspection, palpation, auscultation, and inspection findings—into an organized, searchable format. The format often follows standardized templates, balancing clinical detail with efficiency. This structured approach minimizes omissions common in free-text narratives, thus reducing diagnostic risk. A 2022 study in *Journal of Medical Records* found facilities using structured documentation reduced missed diagnoses by 31% compared to those relying on unstructured notes.

Key Components of Effective Documentation

Each documented element carries weight in patient

management. Vital signs establish baseline physiological status, while inspection and auscultation uncover subtle abnormalities invisible to untrained ears. A systematic breakdown ensures no symptom escapes. For instance, standardized auscultation protocols pinpoint murmurs earlier, enabling timely intervention. Documentation also supports longitudinal tracking; comparing today's chest exam findings to last year's baseline reveals progression or regression.

Technology Integration and Workflow Optimization

Electronic Health Records (EHR) have revolutionized gu physical exam documentation, enabling real-time updates and automated alerts. AI-assisted tools now flag potential documentation gaps, suggesting relevant findings based on patient history. A 2023 analysis by Health Affairs highlighted a 40% improvement in documentation completeness in EHR-integrated settings versus paper-based systems. However, implementation costs and staff training present hurdles. Smaller practices may lack resources, prompting a trade-off between efficiency and accuracy.

Comparative Analysis: Manual vs.

Digital Systems

Manual documentation risks illegibility, lost charts, and delayed access—issues correlated with 15–20% staff time spent on record retrieval, according to American Journal of Nursing.

Digital systems, while requiring upfront investment, offer searchable archives, integration with lab results, and voice-to-text conversion. Yet, over-reliance on templates risks "copy-paste" errors, diluting clinical nuance. The challenge lies in balancing standardization with personalized detail, a balance achieved through hybrid workflows.

Pros and Cons in Documentation Practices

Pros include improved data sharing across care teams, stronger compliance with accreditation standards, and enhanced audit readiness. Structured documentation permits analytics to identify population health trends—such as rising hypertension rates or vaccination gaps. Cons involve documentation fatigue, especially when EHR interface complexity demands excessive keystrokes. A 2021 survey revealed 68% of physicians cite documentation as a top cause of burnout, underscoring design flaws in current systems.

Best Practices for Standardization

Adopting uniform terminology like SNOMED CT or LOINC improves interoperability, preventing misinterpretation across institutions. Periodic staff training maintains proficiency with evolving systems. Peer reviews of documentation logs help identify recurring errors, fostering a culture of quality. The CDC's Physician Documentation Benchmarking Report underscores that practices with standardized checklists achieve 27% higher compliance with care protocols.

Regulatory and Legal Implications

Gu physical exam documentation extends beyond clinical utility—it is a legal artifact. Accurate records defend against liability claims, as seen in malpractice trials where incomplete notes were pivotal. Conversely, vague entries invite scrutiny. HIPAA compliance further dictates secure storage and access controls, preventing breaches that damage patient trust. Regulatory bodies now incentivize robust documentation through bundled payments, reinforcing its financial and ethical importance.

Data-Driven Insights from Documentation

Extracted from exhaustive records, data analytics transform documentation into predictive tools. Machine learning models parse historical exams to forecast outcomes—such as

identifying early sepsis indicators through subtle temperature shifts. A 2023 BMJ study demonstrated that predictive analytics reduced unplanned ICU admissions by 18% via early warning flags. The ability to link exam findings to treatment responses also accelerates evidence-based medicine.

Future Trends and Innovations

Emerging technologies redefine documentation's potential. Natural language processing (NLP) converts voice memos into searchable text, bridging template rigidity and clinician flow. Wearable integration feeds real-time vitals into exams, enabling dynamic assessments. Blockchain may secure longitudinal records, enhancing patient control. Simultaneously, AI could propose differential diagnoses, though human oversight remains essential to avoid algorithmic bias.

Conclusion: Elevating the Standard

Physical exam documentation stands as both a technical and moral imperative. Its evolution—from paper logs to AI-augmented platforms—reflects healthcare's broader shift toward precision and transparency. By prioritizing interoperability, clinician workflow, and patient engagement, documentation becomes more than a record; it is a proactive element of care. As the medical landscape intensifies, mastering this art ensures patient safety, operational efficiency,

and legal protection. The emphasis on rigor in documentation is not mere bureaucracy—it is a commitment to excellence. In reviewing current standards, embracing innovation, and addressing human factors, the profession solidifies its foundation. Only then can gu physical exam documentation fulfill its promise: to deliver timely, accurate, and impactful care.

1. Standardize terminologies across practices
2. Invest in EHR usability training
3. Implement periodic documentation audits
4. Leverage predictive analytics for proactive care

This holistic approach ensures documentation evolves in tandem with medicine itself, reinforcing its role as the bedrock of trustworthy, results-driven healthcare. Article Title: The Critical Role of Gu Physical Exam Documentation in Modern Medicine This comprehensive analysis underscores how meticulous documentation advances clinical outcomes while adapting to technological and regulatory frontiers. In refining these processes, healthcare providers uphold their duty to deliver optimal patient care.

Questions & Answers About gu physical exam documentation

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1	What is included in GU physical exam documentation?	GU physical exam documentation typically includes inspection, palpation, and assessment of the genitalia, urethra, and surrounding structures, noting any abnormalities such as lesions, discharge, swelling, or tenderness.
2	How should findings in a GU physical exam be documented to ensure clarity?	Findings should be documented using clear, concise language, specifying normal or abnormal observations, the location, size, and characteristics of any lesions or masses, and patient responses to palpation or other maneuvers.
3	Why is detailed GU physical exam documentation important in clinical practice?	Detailed documentation is crucial for accurate diagnosis, treatment planning, medico-legal protection, continuity of care, and communication among healthcare providers.
4	What are best practices for documenting a male GU physical exam?	Best practices include noting the condition of the penis, scrotum, testes, epididymis, and hernia assessment, as well as documenting any abnormalities such as swelling, tenderness, or masses, and patient-reported symptoms.
5	How can electronic health records (EHR) optimize GU physical exam documentation?	EHR systems can provide structured templates, checklists, and standardized terminology for GU exams, improving completeness, reducing errors, and facilitating easy retrieval and sharing of exam data.

GU physical exam, genitourinary exam, GU exam documentation, physical examination genitourinary, GU system assessment, genitourinary system exam, GU exam notes, genitourinary physical findings, GU clinical documentation, genitourinary exam template

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