Doctor Name

MBBS

Obstetric & Gynaecologist

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

UHID No. : **Age / Gender :** **Mob. :**

Chief Complaints: **ML:**

Menstrual History: **LMP:**

PRMP:

Obstetric History:

Medical History:

Treatment History: **IUI:**

IVF:

Surgical History:

History of Male Partner:

Occupation:

Addiction:

Medical History:

Surgical History:

	Height	Weight	BMI	Pulse	BP
Female					
Male					

Local Examination:

FEMALE

Blood Group: _____

HB: _____

CBC: _____

RBS: _____

FBS: _____

PPBS: _____

HbA1C: _____

SGPT: _____

S. Creat.: _____

HIV: _____

HbSAg: _____

HCV: _____

VDRL: _____

Hb Electrophoresis: _____

S. Vit B12 _____

S. Vit D3: _____

S. Homocystiene: _____

FSH _____

LH _____

TSH _____

Free T4 _____

AMH _____

Other _____

USG _____

Uterus _____

Cavity _____

Ovaries _____

Tubes _____

AFC _____

SSG/HSG: _____

Hysteroscopy: _____

MALE

Blood Group: _____

HB: _____

CBC: _____

RBS: _____

FBS: _____

PPBS: _____

HbA1C: _____

SGPT: _____

S. Creat.: _____

HIV: _____

HbSAg: _____

HCV: _____

VDRL: _____

Hb Electrophoresis: _____

S. Vit B12 _____

S. Vit D3: _____

S. Homocystiene: _____

FSH _____

LH _____

TSH _____

Free T4 _____

AMH _____

Other _____

USG _____

Semen Analysis: _____

Next Visit

DD / MM / YYYY

Doctor Name

MBBS

Obstetric & Gynaecologist

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myemailid@gmail.com

Patient Name : **Date :**

UHID No. : **Age / Gender :** **Mob. :**

Present Illness:

Menstrual History: LMP: EDD:

Obstetric History:

P/H: Medical:

Surgery:

Allergy:

O/E:

Wt. -

P -

BP -

Pallor -

Oedema -

RS -

CVS -

P/A -

P/S -

P/V -

Breast -

Next Visit

DD / MM / YYYY

- [ ] CBC
- [ ] Blood Group
- [ ] Urine
- [ ] BS
- [ ] GTT
- [ ] HbsAg
- [ ] HCV
- [ ] HIV
- [ ] VDRL
- [ ] TSH
- [ ] Vit B12
- [ ] Vit D3
- [ ] SGPT
- [ ] Creatinine
- [ ] AMH
- [ ] Double Marker
- [ ] Semen Analysis
- [ ] FSH
- [ ] LH
- [ ] Prolactin
- [ ] Insulin
- [ ] Testosterone

USG

- [ ] Abdomen
- [ ] Pelvic / F. Study
- [ ] Obstetrics Scan
- [ ] NT Scan
- [ ] Foetal Anomaly Scan
- [ ] Obstetric Doppler Study
- [ ] Others

Vaccination:

- [ ] HPV
- [ ] Hep B
- [ ] TT
- [ ] TDAP
- [ ] FLU
- [ ] Typhoid
- [ ] Chicken Pox
- [ ] Pneumococcal
- [ ] Anti D

PRESCRIPTION

MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days	Instructions
						Before Food / After Food
						Before Food / After Food
						Before Food / After Food
						Before Food / After Food
						Before Food / After Food
						Before Food / After Food
						Before Food / After Food
						Before Food / After Food
						Before Food / After Food

Next Visit

DD / MM / YYYY

Doctor Name

MBBS, MD
Obstetrics & Gynaecologist

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **UHID No** :

Date/Time : **Age/Gender:** **Mobile No.** :

LAB TESTS ADVISED:

- ☐ Test 1
- ☐ Test 2
- ☐ Test 3
- ☐ Test 4
- ☐ Test 5
- ☐ Test 6
- ☐ Test 7
- ☐ Test 8
- ☐ Test 9
- ☐ Test 10
- ☐ Test 11
- ☐ Test 12

Other Lab Tests

IMAGING TESTS ADVISED:

- ☐ Test 1
- ☐ Test 2
- ☐ Test 3
- ☐ Test 4
- ☐ Test 5
- ☐ Test 6
- ☐ Test 7
- ☐ Test 8
- ☐ Test 9
- ☐ Test 10
- ☐ Test 11
- ☐ Test 12

Other Imaging Tests

Height _____cms **Weight** _____Kg **BMI** _____ **Temp.** _____F

Pulse _____/min **R** _____/min **B.P.** _____mmHg **Pain Score** _____(0-10)

Fall Risk: ☐ Yes ☐ No **Nutritional Status:** ☐ Adequate ☐ Inadequate **Allergy:** _____

Chief Complaints & History: _____

Menstrual History: _____

Obstetric History: _____

Past Medical History: _____

Past Surgical History: _____

Family History: _____

GENERAL EXAMINATION: _____

_____

_____

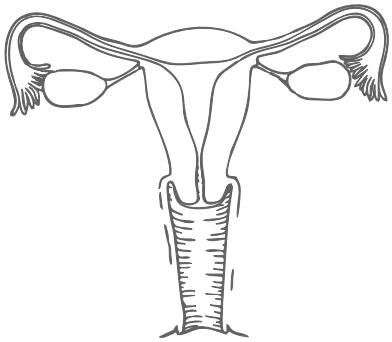
SYSTEMIC EXAMINATION (System applicable):

CVS / Resp. System: _____

P/A: _____

P/V: _____

P/S: _____



PROVISIONAL DIAGNOSIS: _____

_____

TREATMENT PLAN: _____

_____

Admission Advised: If Yes | **Surgery Advised:** If Yes

Procedure Advised: If Yes

Medicine Name (IN CAPITALS)	Dose	Morning	Noon	Night	Days

FOLLOW UP DATE

DD / MM / YYYY

Doctor's Seal & Signature

Doctor Name

MBBS, MD
Obstetrics & Gynaecologist

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **UHID No** :

Date/Time : **Age/Gender:** **Mobile No.** :

LAB TESTS ADVISED:

- [ ] Test 1
- [ ] Test 2
- [ ] Test 3
- [ ] Test 4
- [ ] Test 5
- [ ] Test 6
- [ ] Test 7
- [ ] Test 8
- [ ] Test 9
- [ ] Test 10
- [ ] Test 11
- [ ] Test 12
- [ ] Test 13
- [ ] Test 14
- [ ] Test 15
- [ ] Test 16
- [ ] Test 17
- [ ] Test 18
- [ ] Test 19
- [ ] Test 20
- [ ] Test 21
- [ ] Test 22
- [ ] Test 23
- [ ] Test 24
- [ ] Test 25
- [ ] Test 26
- [ ] Test 27

Other Lab Tests

VITAL SIGNS:

BMI: _____ BP(mm/Hg): _____ Pulse(/min): _____

Temp(℉): _____ Heart Rate: _____ BSA: _____

NUTRITIONAL ASSESSMENTS: Height(cms): _____ Weight(kg): _____

CHIEF COMPLAINTS & HISTORY:

RELEVANT PAST MEDICAL HISTORY:

FAMILY HISTORY:

OBSTETRICS HISTORY:

MENSTRUAL HISTORY:

ALLERGIC TO:

IMAGING TESTS ADVISED:

- ☐ Test 1
- ☐ Test 2
- ☐ Test 3
- ☐ Test 4
- ☐ Test 5
- ☐ Test 6
- ☐ Test 7
- ☐ Test 8
- ☐ Test 9
- ☐ Test 10
- ☐ Test 11
- ☐ Test 12
- ☐ Test 13
- ☐ Test 14
- ☐ Test 15
- ☐ Test 16
- ☐ Test 17

Other Imaging Tests

GENERAL EXAMINATION:

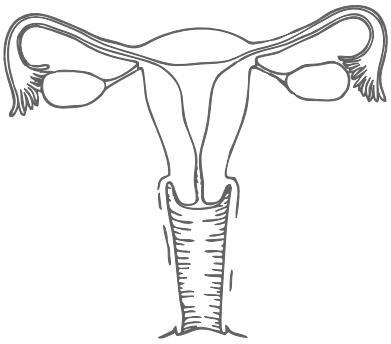
SYSTEMIC EXAMINATION (System applicable):

CVS / Resp. System:

P/A:

P/V:

P/S:



PROVISIONAL DIAGNOSIS:

TREATMENT PLAN:

Admission Advised: If yes

Surgery Advised: If yes

PRESCRIPTION

Sr. No.	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

DD / MM / YYYY