This is a sample, representative template, normally used in clinics. It can be fully customised as per requirement.



## **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:					
<u>Treatment History:</u>	IUI:				
	IVF:				
Surgical History:					
III (					
History of Male Par Occupation:	<u>tner:</u>				
Addiction:					
Medical History:					
Surgical History:					
	Height	Weight	BMI	Pulse	BP

**Local Examination:** 

Female Male

<u>FEMALE</u>	MALE
Blood Group:	Blood Group:
HB:	HB:
CBC:	CBC:
RBS:	RBS:
FBS:	FBS:
PPBS:	PPBS:
HbA1C:	
SGPT:	
S. Creat.:	
HIV:	HIV:
HbSAg:	HbSAg:
HCV:	HCV:
VDRL:	VDRL:
Hb Electrophoresis:	Hb Electrophoresis:
S. Vit B12	S. Vit B12
S. Vit D3:	S. Vit D3:
S. Homocystiene:	S. Homocystiene:
FSH	FSH
LH	LH
TSH	TSH
Free T4	Free T4
AMH	AMH
Other	Other
USG	USG
Uterus	
Cavity	
Ovaries	
Tubes	
AFC	
SSG/HSG:	
Hysteroscopy:	Semen Analysis:

Next Visit

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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/A -		
P -			
BP -	P/S -		
Pallor -			
Oedema -	P/V -		
RS -			
CVS -	Breast -		Next Visit

	СВС						Vac	cination:
Ш							HP\	1
	Blood Group					H		
	Urine					L	Нер	В
	BS					L	TT	
H							TDA	\P
	GTT						FLU	
	HbsAg					H	=	
	HCV					Ļ		hoid
	HIV					L	Chie	cken Pox
							Pne	umococcal
Ш	VDRL						Anti	D
	TSH						7 1116	
	Vit B12							
	Vit D3							
H	SGPT							
	Creatinine							
	AMH							
	Double Marker							
	Semen Analysis							
	FSH							
	LH							
	Prolactin							
H								
Ш	Insulin							
	Testosterone	PRESCRIPTION						
		PRESCRIPTION						
	1100	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days	Instructions
	USG	(With the ord HAL)						
	Abdomen							Before Food  After Food
	Pelvic / F. Study							Before Food
	Obstetrics Scan							After Food
	NT Scan							Before Food
	Foetal Anomaly							After Food
Ш	Scan							Before Food
	Obstetric Doppler							After Food Before Food
Ш	Study							After Food
								Before Food
	Others							After Food
								Before Food
								After Food
								Before Food
								After Food Before Food
					I	I	I	2010101000
								After Food
						Nov	t Visit	After Food



## **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:	Heightcms         WeightKg         BMITempF
Test 1	Pulse/min R/min B.PmmHg Pain Score(0-10)
Test 2	Fall Risk: Yes No Nutritional Status: Adequate Inadequate Allergy:
Test 3	rail Risk: tes No Nutritional Status: Adequate Inducquate Allergy
Test 4	Chief Complaints & History:
Test 5	
Test 6	
Test 7	
Test 8	
Test 9	
Test 10	
Test 11	
Test 12	
Other Lab Tests	Menstrual History:
IMAGING TESTS ADVISED:	
Test 1	
Test 2	Obstetric History:
Test 3	
Test 4	
Test 5	Past Medical History:
Test 6	
Test 7	
Test 8	Past Surgical History:
Test 9	
Test 10	
Test 11	Family History:
Test 12	
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	5		
Procedure Advised: If Yes						
Medicine Name (IN CAPITALS)	Dose	Morning	N	oon	Night	Days
Predictite Natile (IN CAPTIALS)	Dose	Morning	IN	0011	Nigit	Days
FOLLOW UP DATE			Γ			
DD / MM / YYYY				Doct	or'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 :		ı	UHID No :
Date/Time :	Age/Gender:		Mobile No. :
LAB TESTS ADVISED:	VITAL SIGNS:		
Test 1	BMI: E	BP(mm/Hg):	Pulse(/min):
Test 2			
Test 3	Temp(芹):	Heart Rate:	BSA:
Test 4	NUTRITIONAL ASSESSMENTS: Heig	ght(cms):	Weight(kg):
Test 5	CHIEF COMDI AINTS & HISTORY		
Test 6	CHIEF COMPLAINTS & HISTORY.		
Test 7			
Test 8			
Test 9			
Test 10			
Test 11			
Test 12			
Test 13			
Test 14	RELEVANT PAST MEDICAL HISTORY	Y:	
Test 15			
Test 16			
Test 17			
Test 18			
Test 19	FAMILY HISTORY:		
Test 20	TAPILLI III STORTI		
Test 21			
Test 22	OBSTETRICS HISTORY:		
Test 23			
Test 24			
Test 25			
Test 26	MENSTRUAL HISTORY:		
Test 27			
Other Lab Tests	ALLERGIC TO:		



IMA	GING TESTS ADVISED:	GENERAL	EXAMINATION:						
	Test 1								
	Test 2								
	Test 3	st 3							
	Test 4	SYSTEMI	C EXAMINATION	(System appli	cable):				
	Test 5	CVS / Res	p. System:						
	Test 6	P/A:							
	Test 7								
	Test 8	P/V:	P/V:						
	Test 9	P/S:							
	Test 10								
	Test 11		)						
	Test 12		·	\	\				
	Test 13			(					
	Test 14				July Marit				
	Test 15				դրդրուդյ <i>յունը</i> Ահերևոներ				
	Test 16			-					
	Test 17	PPOVISI	ONAL DIAGNOSIS						
		PROVISI	ONAL DIAGNOSIS	·-					
	Other Imaging Tests								
		TREATME	ENT PLAN:						
Δdmiss	sion Advised: If yes								
7 (4111100	ii yee								
Surgery	y Advised: If yes								
		PR	ESCRIPTION		I				
Sr. No.	MEDICINE (WRITE IN CAPITAL)		Dose	Morn	Noon	Night	Days		
			Acuto	2		FOLLO	OW UP DATE		
Doctor's Seal & Signature							M / YYYY		
			Chron	ic		DD / MI	VI / TTTY		