Patient Name: ____

MR #:____

Creek General Hospital

Initial Assessment form (to be filled for initial patients only)

For the Department of Gynecology and Obstetrics (to be filled by Doctors)

Date: ____________________ Weight: ____________________ (Kg) Pulse: _____________/min.
BP_________ mmHg Temperature: _______________ Respiration ______________________ / min

Patient Age (Yrs.) _________	Miscarriages/ Ectopic ______________	Husband age: (Yrs.)
Marital status _____________	previous marriage: Y/N	Cervical smear Y/N
Parity: _______________	EDD _________	**Primary Physician Name & Designation**
Last Delivery: ________	LMP: _______________	

Presenting Complaint: ____

____

____

____

History of Present illness: ____

____

____

____

Menstrual History

Age of Menarche (Yrs.) ____________________
Duration of Cycle: ________________________
Amount of Flow: __________________________
Abnormality in menses ____________________
____
Dysmenorrhea____________________________
____
____
____
Pap smear
Contraceptive use: Y/N
specify ___________________________________

Obstetrics History

____
____
____
____
____
____
____
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____
____
____
____

A/N, Intrapartum/ Postpartum Complications: ____

____

____

____

Medical History & Surgical History ____

____

____

Drug History: ____

Family History: ____

____

General Physical Examination: ____

Obstetric Abdominal Examination Height of Fundus: Presenting Part: Fetal Heart Sounds: Tenderness: Scar Tenderness:	**Gynecological Abdominal Examination** (Tenderness, Mass in Abdomen, Distention)
Obstetric Vaginal/ Rectovaginal Examination: Cervical Dilation, Effacement: Station: Bleeding: Pelvic Adequacy:	**Gynecological Vaginal/ Rectovaginal Examination** Cervical OS Size of Uterus Fornices Cervical Excitation

SPECULAM EXAMINATION ____

____

____

____

PROVISIONAL DIAGNOSIS: ____

____

TREATMENT PLAN ____

____

____

INVESTIGATIONS: ____

____

FOLLOW UP AFTER ______________________Days / week/ months

Referral ☐ Outpatient Specialized Clinic _____________ ☐ Inpatient Admission ☐ others___________

Doctor's Name &Designation: __________________________ Date: _______________ time: ______________