Gynaecological Case Record

Serial No. Hosp. No. Date of admission:

Name: Age: Date of discharge:

Address: Occupation: Married / Unmarried / Widow

Parity score

Complaints:

History of present illness:

Menstrual history:

Flow: Scanty / Moderate / Excessive Age at Menarche: years:

Post Coital / Inter menstrual bleeding

Reg

Last menstrual period / Menopause: Irregular

Obstetrical history: Heavy menstrual bleeding

Marital History:

Para

No. of abortions: No. of deliveries:

No. of children alive: FTND / Forceps / LSCS

Past history Last child birth / abortion

Contraception:

Family history

EXAMINATION:

General Examination:

Pulse: Temp: Blood pressure:

Systemic examination

i) CVS

ii) RS

iii)CNS

iv)Abdominal examination

Gynaecological examination

External genitalia

P/S: Cervix Vagina Cystocele

Rectocele Discharge

Bimanual examination: Cervix

Uterus

Fornices

Rectal Examination:

Provisional diagnosis

Proposed treatment

Investigations

Haemogram	Urine analysis	Stool	HIV
Blood Sugar	Blood urea	Blood Group & Typing	VDRL
Pap smear			HBsAg

USG

EB / D&C / FC / Hysteroscopy / Laparoscopy

X - ray Chest ECG Echo - Others (Specify)

Histopathology report: Pre - Op

Operation Notes:

Date of operation:

Surgeon:

Proposed surgery:

Assistant:

Surgery Performed:

Anaesthesia:

Indication for operation:

Position of the patient:

Preparation:

Incision

Operative findings:

Steps of operation:

Blood loss

Post operative follow - up

Blood replacement

HPE Findings

Final diagnosis

Post operative management

Post operative complications: Fever / Wound infection / UTI / Others

Dated :

Signature of Senior Resident/ Asst. Professor