



Patient record: Gynaecology

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Reason for Visit

Presenting complaint

Visit type

☐ Routine check ☐ Pregnancy ☐ Acute problem ☐ Family planning ☐ Menopause

2. Menstrual History

Age at menarche

Last menstrual period

____ / ____ / ____
dd/mm/yyyy

Cycle length

Regularity

☐ Regular ☐ Irregular

Menstrual pain?

☐ Yes ☐ No

If yes, give details:

Contraception

☐ None ☐ Oral ☐ Intrauterine device ☐ Implant ☐ Barrier ☐ Other

3. Obstetric History

Gravida

Para

Previous pregnancies

Year	Outcome	Weeks	Complications

4. Medical History

Previous gynaecological surgery?

☐ Yes ☐ No

If yes, give details:

Sexually transmitted infections?

☐ Yes ☐ No

If yes, give details:

Family history of breast or ovarian cancer?

☐ Yes ☐ No

If yes, give details:

Last cervical smear

____ / ____ / ____
dd/mm/yyyy

Drug allergies?

☐ Yes ☐ No

If yes, give details:

Current medications

5. Examination and Ultrasound

Physical examination

Ultrasound image

Space for a photo or sketch

Ultrasound date

____ / ____ / ____

dd/mm/yyyy

Ultrasound findings

6. Diagnosis and Plan

Diagnosis

Treatment plan and follow-up

7. Consent

Informed consent

1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.
2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.
3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.
4. I authorize the gynaecologist and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.
5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

Signature

Date

____ / ____ / ____
dd/mm/yyyy