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NOWSHERA MEDICAL COLLEGE

NOWSHERA KPK

**LOG BOOK OBGYN**

**Name of the student**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Year**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Batch** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Session** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Roll No.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INTRODUCTION**

Dear student welcome to the clinical part of your training. This logbook has been designed to assist you in developing the competencies required of you. It is meant to serve as a comprehensive record of all your academic and clinical activities and achievements during the clinical rotation. It has to be maintained regularly by all students. It will contribute substantially towards your continuous assessment. All the entries are to be made on the day of the activity entered and are to be signed by the immediate supervisor.

During clinical rotation, the students need to bring their own instruments as listed below-

1. B.P apparatus
2. Stethoscope
3. Thermometer
4. disposable tongue depressor
5. Tendon hammer
6. Measuring tape
7. Measuring scale (ruler)
8. Pen torch
9. Instrument for checking sensation

|  |
| --- |
| **Clinical guideline for Year03, 04 and 05 MBBs** |
|  |  | Level of competencies to be achieved by the end of rotation  Observed (I)PERFORME WITH ASSISTANT (II)Performed without assistance under the supervision of faculty member(III) |
| **Skills** | **3rd Year** | **Year 04** | **Year 05** |
| History taking, Examination and recording in the standardized format. | III\*\*Ten complete histories are required to be submitted before the end of rotation OSCE examination | III\*\*Five complete histories are required to be submitted before the end of rotation OSCE examination | III\*\*Ten complete histories are required to be submitted before the end of rotation OSCE examination |
| **Clinical skills and Procedures** |  |  |  |
| Gynecological examination including breast examination |  | ll | lll |
| Obstetrical examination |  | ll | lll |
| Bivalve speculum(Cuscus) pelvic examination |  | l | lll |
| Plotting and interpreting partogram |  | ll | lll |
| Interpretation of CTG |  | l | lll |
| Artificial rupture of Membrane |  | l | ll |
| Assessment of FHR |  | ll | lll |
| Use of ocytocic drug |  | l | ll |
| Filling up investigation forms |  | l | ll |
| Patient daily progress report |  | l | lll |
| Care of laboring patient |  | ll | ll |
| Conducting Normal vaginal delivery |  | l | ll |
| Active mange of third stage of labor |  | l | ll |
| Repair of an Episiotomy |  | l | ll |
| Examination of placenta and cord of anomalies |  | l | ll |
| Assessment and recording of APGAR score |  | ll | lll |
| Postpartum Assessment of Perineum, uterine involution and lochia |  | l | ll |
| Insertion and care of urinary catheter |  | ll | lll |
| High Risk pregnancy |  | l | ll |
| Instrumental Delivery/ C/section |  | l | ll |
| Abnormal presentation (Breech) |  | l | ll |
| Abnormal Lie/Cord, Hand prolapsed |  | l | ll |
| Twins delivery |  | l | ll |
| Shoulder Dystochia |  | l | ll |
| Bishop Scoring |  | ll | lll |
| Exploration of Genital tract |  | l | ll |
| Clinical Pelvimetry |  | l | l |
| **Cognitive Or diagnostic Skills** |  |  |  |
| Making provisional diagnose |  | ll | lll |
| Making differential diagnose |  | ll | lll |
| Initiating appropriate clinical Investigation |  | ll | lll |
| Formulating a Final diagnose |  | ll | lll |

|  |  |  |  |
| --- | --- | --- | --- |
| **Skills** |  | **Yaer 04** | **Year 05** |
| **Soft Skills** |  |  |  |
| Counseling (General G-Obs patients for the case specified under competencies |  | ll | lll |
| IUCD counseling and Insertion |  | l | lll |
| Health Education & Promotion (for cases specified under competencies) |  | ll | lll |
| **Procedure** |  |  |  |
| HVS |  | l | ll |
| PAP Smear |  | l | ll |
| Catheterization |  | ll | lll |
| **Patient care related Skills** |  |  |  |
| Organizing Patients admission notes |  | l | ll |
| Putting Patient in comfortable position during examination |  | ll | lll |
| Pre-Op operation of patient |  | ll | lll |
| **Skills** |  | **Year 04** | **Year 05** |
| Operative care |  | l | ll |
| Positioning the patient |  | l | ll |
| Toweling and draping before surgery |  | l | ll |
| Observing surgical procedure (major & Minor) |  | l | ll |
| Identification of surgical instruments |  | lll | lll |
| Organizing patients operative notes |  | l | ll |
| Post OP care |  |  |  |
| Explaining Post OP instruction to the patients and relative/attendants |  | ll | ll |
| Post OP follow |  | l | ll |
| **INVESTIGATION** |  |  |  |
| Base Line Investigations |  | l | lll |
| Specific Investigations |  | l | lll |
| Ultrasound Examination |  | l | ll |
| X-Ray / CT Pelvimetry |  | l | ll |
| HSG |  | l | ll |
| **Planning Management** |  |  |  |
| EmergencyEclampsiaAPHPPHObstetrical Shock |  | ll | lll |
| Non Emergency routine Case |  | ll | lll |
| High Risk Pregnancy |  | ll | lll |

**WORKING CODE FOR STUDENTS**

Dear students, your supervised clinical rotations would prove to be the most valuable experience so if your professional life. To make the best of it ,you would have to acquaint yourself with the norms and working codes of the hospital environment and follow them to the best of your ability. To facilitate your learning at the clinical stations we are providing you some guidelines, which are to be followed.

**1**. The students should wear their overalls (neat & Clean) and ID Badges according to prescribed dress code.

**2**.Thestudents should be very careful about their dress-up during their clinical rotation. The recommended uniform for both male & female students should be strictly followed. Female students should avoid wearing jewelry & high heel shoes. Remember we have sick people in hospital & some might be critical. If the physician are dressed up in party dress it could be up selling & hurtful for the patients & theirs relatives/attends.

**3**.At all-time avoid unnecessary conversation and laughter. This becomes even more true when taking history from a patient.

**4**.All the students would carry their instrument with them during their practical placements and should not use the war or OPD equipment without prior permission.

**5**.All the students have to be punctual and follow the recommended timing regularly.

**6**.The students have to behave decently and have to exhibit responsible & Compassionate behavior towards patients.

**7**.Never forget to introduce yourself to the patients who have been assigned to you. Always explain what you are about to do in a courteous manner using language which the patient can understand. Avoid all types of medical jargon and terminology. Unless a patient is frightened or weakened by illness they usually will co-operate during history taking examination but this become impossible if common courtesy of introducing yourself to the clinical teachers to whom you have been assigned and the nursing staff Incharge of the ward. This will help other to facilitate you during you clinical teaching & Learning, thereby increasing the value of your clinical experience.

**8**.Before starting any history taking or Physical examination consider the patient’s privacy and dignity. Male Medical students shall always have a female chaperone when attending a female patient.

**9**.Remember that the doctor ultimately responsible for any patient’s care is the hospital consultant. Ensure that you know who this person is and refer to the decisions and judgment of these people doesn’t make any remarks that could jeopardize the confidence of the patient in his/her physician.

**10**.Avoid sitting on the patients bed as this give a sloppy impression and is also an invasion of the patient’s privacy. Beside it is a health hazard for the students too.

**11**.Don’t not forget to close doors or pull curtains around ward bed before embarking on history of carrying out a physical examination.

**12**.Never make comments of an explicit nature in front of a patient (e.g. questioning the seriousness of a patients problem, most of the problem that take a person to hospital are considered serious by the patient and their relatives).

**13**.Never discuss or refer to any patients in front of another. This also includes exercise care to references of patient related matter in public places where your comments can be over headed and reported to any in appropriate person.

**14**.The students are required to maintain discipline and adopt a respectful attitude towards their clinical supervisors and teachers.

**15**.Medical students will often be in group with a clinical teacher. Do not continue conversation among yourselves when a doctor is addressing a patient. Remember some clinical teachers prefer you to give them all your concentration and not make notes while they are addressing you as a group or individually. If you wish to make notes ask first.

**16**. Eat only those places as signed for eating and always wash your hands before and after doing so. It is safe practice to wash your hands before leaving ward.

**17**.Hospital and clinics are places where rumors and gossip can be frequent; no student shall indulge in this at all. He/She shall respect the confidentiality and privacy of every patient’s personal details. Similarly gossip about any staff member (doctor, nurse, paramedic & supporting staff) is deplorable, hurtful and unprofessional.

**18**.If you don’t find your clinical teacher for a scheduled clinical teaching session, you must not forget that any medical staff may be delayed for some very good reason. Before wandering away from a pre-arranged meeting with a clinical teacher try and investigate first where you are waiting for your teacher. You must be patient because emergencies do not respect student’s time tables. An alternate resources person will be always available in plead of the original teacher.

**19**.Strictly follow the guideline/Hospital polices regarding infection control

**20**.Do not discriminate against any patient on the basis of race, color, Creed, national origin

**21**.Observe all responsible self-protection & patient safety precautions and never go to another patient after having touched one without washing your hands, even if you have worn gloves. There may have been small puncture in your glove, Bear in mind that many patients arrive in a hospital or attend a clinic without a clear diagnosis being possible. Assumptions about their safety can be both unjustified and at worst dangerous. Properly dispose of fall the needles & sharp objects(take guidance from the hospital staff).

**22**.Always seek permission first from the ward staff/doctor before using ward instruments, patient’s case notes, X-rays, investigations etc. and make sure to put them back correctly after use

.

**23**.If any of the students is found to breach the working code He/She would be liable to disciplinary action.

**CLINICAL ROTATION YEAR 03**

From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

special Notes by the students

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gynecology and Obstetrics Year 03

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.No** | **Date** | **Competencies** | **Level**A. Observer statusB. Assistat statusC. Performed part of the procedure under supervisionD. Performed whole procedure under supervisionE. Independent performance | **Supervisor****Comments****Signature** |
| A | B | C | D | E |
| 1. |  | History taking from a patient in Gynae/obs unit |  |  |  |  |  |  |
|  |  | General physical examination |  |  |  |  |  |  |
| Pulse |  |  |  |  |  |  |
| BP |  |  |  |  |  |  |
| temp |  |  |  |  |  |  |
| Respiratory rate |  |  |  |  |  |  |
| Others (Specify) |  |  |  |  |  |  |
|  |  | Vagina/pelvic examinationObstetric Examination |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Other (Specify) |  |  |  |  |  |  |
| Deliveries Normal vaginal |  |  |  |  |  |  |
| Forceps |  |  |  |  |  |  |
| Vacuum |  |  |  |  |  |  |
| C-section |  |  |  |  |  |  |

**Details of other activities 03**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor's comments / signature** |
| Introduction to common symptoms and diseases in Gynae / obs. | Presented by: |  |
| Details of history and examination \* You have to write 2 histories in each wardAlong with examination,ProvisionalDiagnosis, relevant investigations,ResultsOf procedures, final diagnosis,TreatmentAnd follow- up protocol | \* Mention 3 symptoms and system involved.1)2)3) |  |
| Case based discussion (CBD) | Supervised by |  |
| Role plays/ Breaking bad news | Role plays |  |
| End of the are assessment | Marks.\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Any other event that you want to record during your stay in the unit (Provide details) |  |

**Feedback form for year 03**

|  |  |  |
| --- | --- | --- |
| **S.No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| **1** | Was polite with patients, nurses, paramedical staff, Seniors and juniors |  |  |  |
| **2** |  Was ready to take responsibility |  |  |  |
| **3** |  Kept calm in difficult situations |  |  |  |
| **4** | Maintained an appropriate appearance/Dress |  |  |  |
| **5** | Avoided derogatory remarks in the unit |  |  |  |
| **6** | Presentation skills were up to the mark |  |  |  |
| **7** | Overall assessment of professional conduct |  |  |  |
| **8** | Overall assessment of professional conduct |  |  |  |

**Student's Name** **…………………………………………………………………………………………………………….**

**Roll Number …………………………………………………. Batch……………………………………………………..**

**Clinical rotation in …………………………………………. from (date)……………………to………………………..**

**END ROTATION ASSESSMENT 03**

|  |  |  |
| --- | --- | --- |
| **Category**  | **Total marks** | **Student's score** |
| End-of-rotation OSCE |  |  |
| SGD |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Total number of days** | **Days Attended** |
| **Attendance** |  |  |

**Student's log of clinical sign/Examinations 03**

|  |
| --- |
| **LEVELS**Observed (I)Performed with assistant (II)Performed without assistance under the supervision of faculty member(III) |
| **S.No.** | **Date** | **Name of patient** | **Registration No** | **Diagnosis** | **Procedures** | **level** | **Sign** |
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**Student's log of clinical sign/Examinations 03**

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| --- |
| **LEVELS**Observed (I)Performed with assistant (II)Performed without assistance under the supervision of faculty member(III) |
| **S.No.** | **Date** | **Name of patient** | **Registration No** | **Diagnosis** | **Procedures** | **level** | **Sign** |
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**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 03**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMP (first day of the last Menstrual period)

EDD (Expected date of Delivery)

POG (period of gestation)

**Chief Complaints:**

**History of presenting illness**

**Obstetric History**

**Past History**

**Family History**

**Menstrual History**

**Current Pregnancy**

**Socioeconomic History**

**Drug History**

**Allergy**

**CLINICAL EXAMINATION**

**General physical examination**:

General appearance Blood pressure Pulse

Temperature Respiratory rate

Pallor/jaundice/JVP/LN/thyroid/oedema

Breast examination

**Systemic examination:**

Gastrointestinal examination

Cardiovascular

Nervous system

Respiratory

Genitourinary

**Obstetrical examination:**

Abdominal examination

 **Inspection**

 **Palpation**

 **Percussion**

 **Auscultation**

**Vaginal examination**

 **P/Speculum Examination**

 **P/V examination**

**Differential diagnosis**

**Investigation**

**Management plan**

**Final diagnosis**

**Pre-op preparation**

**Operative procedure**

**Post operative plan**

**Follow up notes**

**Condition on discharge**

**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 03**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMP (first day of the last Menstrual period)

EDD (Expected date of Delivery)

POG (period of gestation)

**Chief Complaints:**

**History of presenting illness**

**Obstetric History**

**Past History**

**Family History**

**Menstrual History**

**Current Pregnancy**

**Socioeconomic History**

**Drug History**

**Allergy**

**CLINICAL EXAMINATION**

**General physical examination**:

General appearance Blood pressure Pulse

Temperature Respiratory rate

Pallor/jaundice/JVP/LN/thyroid/oedema

Breast examination

**Systemic examination:**

Gastrointestinal examination

Cardiovascular

Nervous system

Respiratory

Genitourinary

**Obstetrical examination:**

Abdominal examination

 **Inspection**

 **Palpation**

 **Percussion**

 **Auscultation**

**Vaginal examination**

 **P/Speculum Examination**

 **P/V examination**

**Differential diagnosis**

**Investigation**

**Management plan**

**Final diagnosis**

**Pre-op preparation**

**Operative procedure**

**Post operative plan**

**Follow up notes**

**Condition on discharge**

**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 03**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**History of presenting illness**

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**Past History**

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**Drug History**

**Allergy**

**CLINICAL EXAMINATION**

**General physical examination**:

General appearance Blood pressure Pulse

Temperature Respiratory rate

Pallor/jaundice/JVP/LN/thyroid/oedema

Breast examination

**Systemic examination:**

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Cardiovascular

Nervous system

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 **Inspection**

 **Palpation**

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 **P/Speculum Examination**

 **P/V examination**

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**Management plan**

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**Post operative plan**

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**Condition on discharge**

**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 03**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CLINICAL ROTATION YEAR 04**

From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

special Notes by the students

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Gynecology and Obstetrics year04

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.No** | **Date** | **Competencies** | **Level**A. Observer statusB. Assistat statusC. Performed part of the procedure under supervisionD. Performed whole procedure under supervisionE. Independent performance | **Supervisor****Comments****Signature** |
| A | B | C | D | E |
| 1. |  | History taking from a patient in Gynae/obs unit |  |  |  |  |  |  |
|  |  | General physical examination |  |  |  |  |  |  |
| Pulse |  |  |  |  |  |  |
| BP |  |  |  |  |  |  |
| temp |  |  |  |  |  |  |
| Respiratory rate |  |  |  |  |  |  |
| Others (Specify) |  |  |  |  |  |  |
|  |  | Vagina/pelvic examinationObstetric Examination |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Other (Specify) |  |  |  |  |  |  |
| Deliveries Normal vaginal |  |  |  |  |  |  |
| Forceps |  |  |  |  |  |  |
| Vacuum |  |  |  |  |  |  |
| C-section |  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor's comments / signature** |
| Introduction to common symptoms and diseases in Gynae / obs. | Presented by: |  |
| Details of history and examination \* You have to write 2 histories in each wardAlong with examination,ProvisionalDiagnosis, relevant investigations,ResultsOf procedures, final diagnosis,TreatmentAnd follow- up protocol | \* Mention 3 symptoms and system involved.1)2)3) |  |
| Case based discussion (CBD) | Supervised by |  |
| Role plays/ Breaking bad news | Role plays |  |
| End of the are assessment | Marks.\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Any other event that you want to record during your stay in the unit (Provide details) |  |

**Student's log of clinical sign/Examinations year 04**

|  |
| --- |
| **LEVELS**Observed (I)Performed with assistant (II)Performed without assistance under the supervision of faculty member(III) |
| **S.No.** | **Date** | **Name of patient** | **Registration No** | **Diagnosis** | **Procedures** | **level** | **Sign** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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**Student's log of clinical sign/Examinations**

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| **LEVELS**Observed (I)Performed with assistant (II)Performed without assistance under the supervision of faculty member(III) |
| **S.No.** | **Date** | **Name of patient** | **Registration No** | **Diagnosis** | **Procedures** | **level** | **Sign** |
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**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS Year 04**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMP (first day of the last Menstrual period)

EDD (Expected date of Delivery)

POG (period of gestation)

**Chief Complaints:**

**History of presenting illness**

**Obstetric History**

**Past History**

**Family History**

**Menstrual History**

**Current Pregnancy**

**Socioeconomic History**

**Drug History**

**Allergy**

**CLINICAL EXAMINATION**

**General physical examination**:

General appearance Blood pressure Pulse

Temperature Respiratory rate

Pallor/jaundice/JVP/LN/thyroid/oedema

Breast examination

**Systemic examination:**

Gastrointestinal examination

Cardiovascular

Nervous system

Respiratory

Genitourinary

**Obstetrical examination:**

Abdominal examination

 **Inspection**

 **Palpation**

 **Percussion**

 **Auscultation**

**Vaginal examination**

 **P/Speculum Examination**

 **P/V examination**

**Differential diagnosis**

**Investigation**

**Management plan**

**Final diagnosis**

**Pre-op preparation**

**Operative procedure**

**Post operative plan**

**Follow up notes**

**Condition on discharge**

**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 04**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMP (first day of the last Menstrual period)

EDD (Expected date of Delivery)

POG (period of gestation)

**Chief Complaints:**

**History of presenting illness**

**Obstetric History**

**Past History**

**Family History**

**Menstrual History**

**Current Pregnancy**

**Socioeconomic History**

**Drug History**

**Allergy**

**CLINICAL EXAMINATION**

**General physical examination**:

General appearance Blood pressure Pulse

Temperature Respiratory rate

Pallor/jaundice/JVP/LN/thyroid/oedema

Breast examination

**Systemic examination:**

Gastrointestinal examination

Cardiovascular

Nervous system

Respiratory

Genitourinary

**Obstetrical examination:**

Abdominal examination

 **Inspection**

 **Palpation**

 **Percussion**

 **Auscultation**

**Vaginal examination**

 **P/Speculum Examination**

 **P/V examination**

**Differential diagnosis**

**Investigation**

**Management plan**

**Final diagnosis**

**Pre-op preparation**

**Operative procedure**

**Post operative plan**

**Follow up notes**

**Condition on discharge**

**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 04**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMP (first day of the last Menstrual period)

EDD (Expected date of Delivery)

POG (period of gestation)

**Chief Complaints:**

**History of presenting illness**

**Obstetric History**

**Past History**

**Family History**

**Menstrual History**

**Current Pregnancy**

**Socioeconomic History**

**Drug History**

**Allergy**

**CLINICAL EXAMINATION**

**General physical examination**:

General appearance Blood pressure Pulse

Temperature Respiratory rate

Pallor/jaundice/JVP/LN/thyroid/oedema

Breast examination

**Systemic examination:**

Gastrointestinal examination

Cardiovascular

Nervous system

Respiratory

Genitourinary

**Obstetrical examination:**

Abdominal examination

 **Inspection**

 **Palpation**

 **Percussion**

 **Auscultation**

**Vaginal examination**

 **P/Speculum Examination**

 **P/V examination**

**Differential diagnosis**

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**Final diagnosis**

**Pre-op preparation**

**Operative procedure**

**Post operative plan**

**Follow up notes**

**Condition on discharge**

**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 04**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMP (first day of the last Menstrual period)

EDD (Expected date of Delivery)

POG (period of gestation)

**Chief Complaints:**

**History of presenting illness**

**Obstetric History**

**Past History**

**Family History**

**Menstrual History**

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Breast examination

**Systemic examination:**

Gastrointestinal examination

Cardiovascular

Nervous system

Respiratory

Genitourinary

**Obstetrical examination:**

Abdominal examination

 **Inspection**

 **Palpation**

 **Percussion**

 **Auscultation**

**Vaginal examination**

 **P/Speculum Examination**

 **P/V examination**

**Differential diagnosis**

**Investigation**

**Management plan**

**Final diagnosis**

**Pre-op preparation**

**Operative procedure**

**Post operative plan**

**Follow up notes**

**Condition on discharge**

**HISTORY SHEETS FOR GYNECOLOGY AND OBSTETRICS YEAR 04**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Husband Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of Marriage\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Date of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mode of Admission\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of operation/Delivery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gravida\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_Para\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMP (first day of the last Menstrual period)

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**History of presenting illness**

**Obstetric History**

**Past History**

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**Menstrual History**

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**CLINICAL EXAMINATION**

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General appearance Blood pressure Pulse

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**Systemic examination:**

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Cardiovascular

Nervous system

Respiratory

Genitourinary

**Obstetrical examination:**

Abdominal examination

 **Inspection**

 **Palpation**

 **Percussion**

 **Auscultation**

**Vaginal examination**

 **P/Speculum Examination**

 **P/V examination**

**Differential diagnosis**

**Investigation**

**Management plan**

**Final diagnosis**

**Pre-op preparation**

**Operative procedure**

**Post operative plan**

**Follow up notes**

**Condition on discharge**

**Feedback form for year 04**

|  |  |  |
| --- | --- | --- |
| **S.No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| **1** | Was polite with patients, nurses, paramedical staff, Seniors and juniors |  |  |  |
| **2** |  Was ready to take responsibility |  |  |  |
| **3** |  Kept calm in difficult situations |  |  |  |
| **4** | Maintained an appropriate appearance/Dress |  |  |  |
| **5** | Avoided derogatory remarks in the unit |  |  |  |
| **6** | Presentation skills were up to the mark |  |  |  |
| **7** | Overall assessment of professional conduct |  |  |  |
| **8** | Overall assessment of professional conduct |  |  |  |

**Student's Name** **…………………………………………………………………………………………………………….**

**Roll Number …………………………………………………. Batch……………………………………………………..**

**Clinical rotation in …………………………………………. from (date)……………………to………………………..**

**END ROTATION ASSESSMENT**

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| --- | --- | --- |
| **Category**  | **Total marks** | **Student's score** |
| End-of-rotation OSCE |  |  |
| SGD |  |  |

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|  | **Total number of days** | **Days Attended** |
| **Attendance** |  |  |

**CLINICAL ROTATION YEAR 05**

From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

special Notes by the students

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Gynecology and Obstetrics

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| **S.No** | **Date** | **Competencies** | **Level**A. Observer statusB. Assistat statusC. Performed part of the procedure under supervisionD. Performed whole procedure under supervisionE. Independent performance | **Supervisor****Comments****Signature** |
| A | B | C | D | E |
| 1. |  | History taking from a patient in Gynae/obs unit |  |  |  |  |  |  |
|  |  | General physical examination |  |  |  |  |  |  |
| Pulse |  |  |  |  |  |  |
| BP |  |  |  |  |  |  |
| temp |  |  |  |  |  |  |
| Respiratory rate |  |  |  |  |  |  |
| Others (Specify) |  |  |  |  |  |  |
|  |  | Vagina/pelvic examinationObstetric Examination |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
| Other (Specify) |  |  |  |  |  |  |
| Deliveries Normal vaginal |  |  |  |  |  |  |
| Forceps |  |  |  |  |  |  |
| Vacuum |  |  |  |  |  |  |
| C-section |  |  |  |  |  |  |

**Details of other activities**

|  |  |  |
| --- | --- | --- |
| **Competencies** | **Details** | **Supervisor's comments / signature** |
| Introduction to common symptoms and diseases in Gynae / obs. | Presented by: |  |
| Details of history and examination \* You have to write 2 histories in each wardAlong with examination,ProvisionalDiagnosis, relevant investigations,ResultsOf procedures, final diagnosis,TreatmentAnd follow- up protocol | \* Mention 3 symptoms and system involved.1)2)3) |  |
| Case based discussion (CBD) | Supervised by |  |
| Role plays/ Breaking bad news | Role plays |  |
| End of the are assessment | Marks.\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  |
| Any other event that you want to record during your stay in the unit (Provide details) |  |

**Student's log of clinical sign/Examinations year 05**

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| **LEVELS**Observed (I)Performed with assistant (II)Performed without assistance under the supervision of faculty member(III) |
| **S.No.** | **Date** | **Name of patient** | **Registration No** | **Diagnosis** | **Procedures** | **level** | **Sign** |
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**Student's log of clinical sign/Examinations**

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| --- |
| **LEVELS**Observed (I)Performed with assistant (II)Performed without assistance under the supervision of faculty member(III) |
| **S.No.** | **Date** | **Name of patient** | **Registration No** | **Diagnosis** | **Procedures** | **level** | **Sign** |
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**Feedback form for year 05**

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| --- | --- | --- |
| **S.No** | **Statement** | **Supervisor comments** |
| **Yes** | **No** | **Any other point** |
| **1** | Was polite with patients, nurses, paramedical staff, Seniors and juniors |  |  |  |
| **2** |  Was ready to take responsibility |  |  |  |
| **3** |  Kept calm in difficult situations |  |  |  |
| **4** | Maintained an appropriate appearance/Dress |  |  |  |
| **5** | Avoided derogatory remarks in the unit |  |  |  |
| **6** | Presentation skills were up to the mark |  |  |  |
| **7** | Overall assessment of professional conduct |  |  |  |
| **8** | Overall assessment of professional conduct |  |  |  |

**Student's Name** **…………………………………………………………………………………………………………….**

**Roll Number …………………………………………………. Batch……………………………………………………..**

**Clinical rotation in …………………………………………. from (date)……………………to………………………..**

**END ROTATION ASSESSMENT 05**

|  |  |  |
| --- | --- | --- |
| **Category**  | **Total marks** | **Student's score** |
| End-of-rotation OSCE |  |  |
| SGD |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Total number of days** | **Days Attended** |
| **Attendance** |  |  |