Dr. Prathusha K | Endogynecologist

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PATIENT INTAKE FORM

Confidential: This information is protected and accessible only to you and your doctor (DPDP Act, 2023)

1. Personal Details

Full Name: _____

Date of Birth: _____ Age: _____

Phone Number: _____ Email: _____

Address: _____

Emergency Contact (Name & Phone): _____

2. Medical History

Reason for today's visit: _____

Current medications (incl. supplements): _____

Known allergies: _____

Previous surgeries / procedures: _____

Chronic conditions (diabetes, thyroid, BP, etc.): _____

3. Obstetric & Gynaecological History

Last menstrual period (LMP): _____ Cycle regularity: _____

Number of pregnancies / deliveries: _____

Currently pregnant or planning pregnancy?: _____

Previous gynaecological treatments: _____

4. Consent

I confirm the above information is accurate. I consent to examination and treatment, and to the secure processing of my health information for the purpose of my care, as per applicable Indian privacy laws.

Patient Signature: _____ Date: _____