Annexure – 8 (Total 3 pages)

This checklist is to be filled by the doctor before commencing the sterilization procedure for ensuring the eligibility and fitness of the client for sterilization.

Name of Health Facility: ……

Beneficiary Registration Number: ……

Date…….....

A. Eligibility Checklist

Client is within eligible age	....Yes .....No
Client is ever married	Yes..... No.....
Client has at least one child over one year of age	Yes..... No.....
Lab investigations (Hb, urine) undertaken are within normal limits (7.0 gms or more)	Yes..... No.....
Medical status as per clinical observation is within normal limits	Yes..... No.....
Mental status as per clinical observation is normal	Yes..... No.....
Local examination done is normal	Yes..... No.....
Informed consent given by the client	Yes..... No.....
Explained to the client that consent form has uthority of a legal document	Yes..... No.....
Abdominal/Pelvic examination has been done in the female and is within normal limits	Yes..... No.....
Infection prevention practices as per laid down standards	Yes..... No.....

B. Menstrual History (for female clients)

Cycle Days	
Length	
Regularity	Regular…….. Irregular……
Date of LMP (DD/MM/YYYY)	..... /..... /.....

C. Obstetric History (for female clients)

Number of Spontaneous Abortions	
Number of Induced Abortions	
Currently Lactating	Yes..... No.....
Amenorrheic	Yes..... No.....
Whether Pregnant	Yes..... No..... If Yes (No. of weeks pregnancy)……..
No. of Children	Total No…….
Date of Birth of Last Child (dd/mm/yyyy)	..... /..... /.....

D. Contraceptive History

Have you or your spouse ever used contraception?	Yes..... No.....
Are you or your spouse currently using any contraception or have you or your spouse used any contraception during the last six months? *(✓) Tick the option*	• None……..…….. • IUCD……..……... • Condoms……..…….. • Oral Pills……..…….. • Any Othe (specify)……

E. Medical History

Recent medical Illness	Yes..... No.....
Previous Surgery	Yes..... No.....
Allergies to medication	Yes..... No.....
Bleeding Disorder	Yes..... No.....
Anemia	Yes..... No.....
Diabetes	Yes..... No.....
Jaundice or liver disorder	Yes..... No.....
RTI/STI/PID	Yes..... No.....
Convulsive disorder	Yes..... No.....
Tuberculosis	Yes..... No.....
Malaria	Yes..... No.....
Asthma	Yes..... No.....
Heart Disease	Yes..... No.....
Hypertension	Yes..... No.....
Mental Illness	Yes..... No.....
Sexual Problems	Yes..... No.....
Prostatitis (Male sterilization)	Yes..... No.....
Epididymitis (Male Sterilization)	Yes..... No.....
H/O Blood Transfusion	Yes..... No.....
Gynecological problems (Female Sterilization)	Yes..... No.....
Currently on medication (if yes specify)	Yes..... No.....

Comments……

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F. Physical Examination

BP……Pulse……..Temperature……..

Lungs	Normal…….. Abnormal……
Heart	Normal…….. Abnormal……
Abdomen	Normal…….. Abnormal……

Annexure – 8 (Total 3 pages)

G. Local Examination (Strikeout whichever is not applicable) 1. Male Sterilization

Skin of Scrotum	Normal…..…….. Abnormal…..……
Testis	Normal…..…….. Abnormal…..……
Epididymis	Normal…..…….. Abnormal…..……
Hydrocele	Yes…..…….. No…..……
Varicocele	Yes…..…….. No…..……
Hernia	Yes…..…….. No…..……
Vas Deferens	Normal…..…….. Abnormal…..……
Both Vas Palpable	Yes…..…….. No…..……

2. Female Sterilization

External Genitalia	Normal…..…….. Abnormal…..……
PS Examination	Normal…..…….. Abnormal…..……
PV Examination	Normal…..…….. Abnormal…..……
Uterus Position	A/V……..R/V……..…… Mid position…..Not determined…..…
Uterus size	Normal……..Abnormal - Size……
Uterus Mobility	Yes……No..... (Restricted / Fixed)
Cervical Erosion	Yes…..…….. No…..……
Adnexa	Normal…..…….. Abnormal…..……

Comments……..

……..

H. Laboratory Investigations

Hemoglobin level	……..……Gms%
Urine: Albumin	Yes…….. No…..……
Urine- Sugar	Present…….. Absent……..….
Urine test for Pregnancy	Positive: ……..…. Negative: ……..
Any Other (specify)	……..……

Name:..... Signature of the Examining Doctor

Date: ..... **HOSPITAL SEAL**