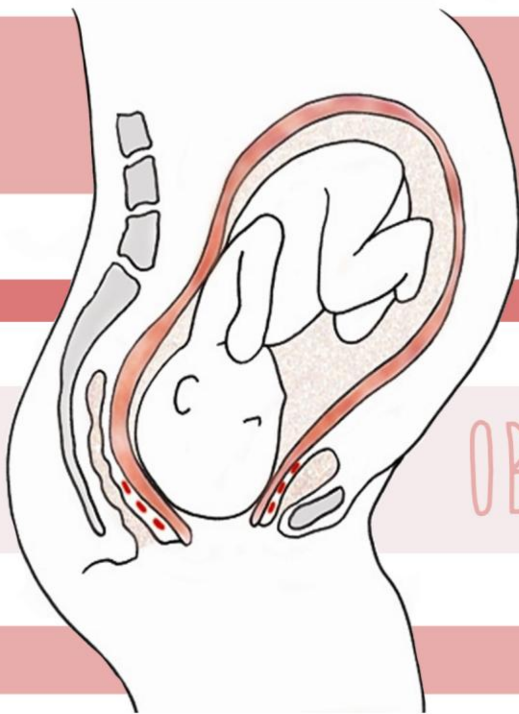

OBSTETRICS AND GYNECOLOGY

History Taking OBGYNE

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Doctor's note Team's note Not important Important

Objectives:

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Hx

1] Pt data
- Name*
- Age*
- Marital status* – How many marriages??
- No. of children & their ages *
- Nationality
- Region
- Gender – 99,99% females
- G P A L
  - G=gravidity (any confirmed pregnancy regardless of gestational age)
  - P=parity (any pregnancy > 20 wks regardless viability or number of fetuses)
  - A=abortion (any death ≤ 20 wks could be spontaneous or induced)
  - L=living births

2] Chief complaint
- Time of admission
- Route of admission
  - Electively (OPC)
  - Emergency
- Complaining of>
- Duration

3] Hx of the Presenting Illness
- Analyzing Chief complaint
  - SO SCARED !!
  - Site
  - Onset
  - Severity if painful – 1-10
  - Coarse
  - Character
  - Aggravating factors
  - Relieving factors
  - Radiation
  - End
  - Duration of feeling it
- Related Risk Factors
- Constitutional Symptoms
  - Fever
  - Night sweating
  - Weight gain or loss
  - Anorexia
- Other symptoms

4] Menstrual Hx
- Age of menarche
- LMP – The first day of the menstrual cycle
- Cycle length [Intermenstrual Interval]
- Beeding characteristics
  - Amount – # of pads
  - +/- Clots
  - Spotting
  - Color
  - Frequency
  - Duration
  - Odor
  - Associated symptoms
- Estimated due date [EDD] – Naegl's rule
  - +7 to the days
-3 to the months (+9)
+1 to the year
to the LMP – e.g. LMP=11/11/2011
EDD=18/8/2012
  - If +7 to the days enters the next month do:
+7 to the days
-2 to the months (+10)
+1 to the year
to the LMP – e.g. LMP=30/11/2011
EDD=7/9/2012
- Gestational age – Every 3 months account for 13 weeks

5] Contraceptive Hx
- Was the pregnancy planned or not ??
- Condoms
- Spermocides
- OCP's & type
- IUCD & type
- others..

7] Past Hx

- Any medical problem
  - ASK!!! Since when?? How it is controlled??
- Surgeries
- Allergies
- Previous hospital admission
- Previous investigations
  - Obstetric bookings
    - Date of first booking
    - Gestational age at first booking
    - Follow up regularly or not
    - At what hospital she did the investigations
  - Gynecological investigations
    - -Pap smear
    - -Cultures
    - -Others
- Blood Hx
  - Blood type
  - Hx of blood transfusion
- Medications
  - Current
  - Previous
  - For what??
  - Compliance??

8] Social Hx

- Occupation*
- Habits
  - Smoking
  - Alcohol
- Habitat*
  - Where??
  - Far or near the hospital
  - With whom??
- Hx of traveling or infected people contact
- Pets contact (Milk)
- Sexual Hx
  - Sexually active +/-
  - Any problems with intercourse
  - STD's
- Domestic violence/Abuse

9] Family Hx

- Health status of the family
- Familial diseases or conditions
- Pt's disease, is it in the family?

10] Function Hx

- Does it effect on daily activities?

HISTORY

What happened from the beginning of this pregnancy till the time of presentation?

1-General information

- **Name**
- **Age**
- **Gravidity**
- **Parity**
- **LMP,**
- **EDD (Naegele's rule)**
    - **Is to add 9 months and 7 days to the first day of the last normal menstrual period example:**
    - **LMP: July 20, 2008**
    - **EDC: April 27,2009**
    - **This Is in Gregorian date but if it is in Hijri add 18 days instead of 7 days**
    - **Average cycle is 28 days and it can be from 21 to 35 days**
    - **If it is 21= add one day , 28= add 7 days , 35= add 14 days**
    -
- **Gravidity** = no. Of pregnancies including current pregnancy (regardless of the outcome N or abortion)
- **Parity** = no. Of births beyond 24 wk gestation

2-Current problem/ complaint

3-History of current complaint

4-History of current pregnancy

- Details of the 1st, 2nd & 3rd trimester
- Lab tests & U/S scans pattern

5-Menstrual & gynecological history

- LMP details (was it conform to the usual in terms of timing, volume, and appearance)
- Regular or irregular cycles
- Length of the cycle
- OCP
- Surgical procedures
- Hx of infertility
- Sexually transmitted diseases
- Uterine anomalie
    - **Dysmenorrhea (age of onset, severity and character of the cramp)**
    - **Age of menarche**
    - **Interval between periods**
    - **Duration of menses**
    - **Character of the flow (scan, normal, heavy, clot).**

6-Past obstetric history

- **Outcome of previous pregnancies** (date and location of delivery, duration of gestation and labor, type of delivery and anesthesia, newborn weight and gender) **in details including the abortions.**
- **Any significant antenatal, intrapartum or postpartum events**
- **Previous maternal complications**
- **Life & health of the baby**
- **Ask in details about 1st pregnancy then move to the 2nd, 3rd, 4th ...etc.**

7-Past medical/ surgical Hx

Some medical conditions may have impact on the course of the pregnancy or the pregnancy may have an impact on the medical condition examples:

- Heart disease
- Hypertension
- Dm
- Epilepsy

- Thyroid disease
- Bronchial asthma
- Any previous surgery.
- Kidney disease
- UTI
- Autoimmune disease
- Psychiatric disorders
- Hepatitis
- Venereal diseases
- Blood transfusion (can develop antibodies)
- Rheumatoid arthritis (improve with pregnancy due to high level of cortisol)
- Trauma must be also listed (fractured pelvis may result in diminished pelvic capacity)
- Previous surgery (if severe adhesion then she might undergo cesarean section instead of vaginal delivery)

8- Drug Hx and contraceptive Hx

- This information is important because oral contraceptives taken during early pregnancy have been associated with birth defect, pre-term delivery and early pregnancy loss.

9- Family Hx

- Hereditary illness → DM., HTN., thalassemia, sickle cell disease, hemophilia
- Congenital defects eg. Neural tube defects, Down Syndrome
- Twins

10-Social Hx

- → Cigarette smoking, illegal drug use, domestic violence and animal exposure (like cats which carry a risk for toxoplasmosis)

From essential of ob+gune

Obstetric History A complete history must be recorded at the time of the prepregnancy evaluation or at the initial antenatal visit. Several detailed standardized forms are available, but this should not negate the need for a detailed chronologic history taken personally by the physician who will be caring for the patient throughout her pregnancy. While taking the history, major opportunities will usually arise to provide counseling and explanations that serve to establish rapport and a supportive patient–physician encounter.

PREVIOUS PREGNANCIES Each prior pregnancy should be reviewed in chronologic order and the following information recorded

The doctor should always: • Knock before entering the patient's room. • Identify himself or herself. • Meet the patient initially when she is fully dressed, if possible. • Address the patient courteously and respectfully. • Respect the patient's privacy and modesty during the interview and examination. • Ensure cleanliness, good grooming, and good manners in all patient encounters. • Beware that a casual and familiar approach is not acceptable to all patients; it is generally best to avoid addressing an adult patient by her first name. • Maintain the privacy of the patient's medical information and records. • Be mindful and respectful of any cultural preferences.

1. Date of delivery (or pregnancy termination)

2. Location of delivery (or pregnancy termination)

3. **Duration of gestation** (recorded in weeks). When correlated with birth weight, this information allows an assessment of fetal growth patterns. The gestational age of any spontaneous abortion is of importance in any subsequent pregnancy.

4. Type of delivery (or method of terminating pregnancy). This information is important for planning the method of delivery in the present pregnancy. A difficult forceps delivery or a cesarean section may require a personal review of the labor and delivery records.

5. **Duration of labor** (recorded in hours). This may alert the physician to the possibility of an unusually long or short labor.

6. Type of anesthesia. Any complications of anesthesia should be noted.

7**. Maternal complications**. Urinary tract infections, vaginal bleeding, hypertension, and postpartum complications may be repetitive; such knowledge is helpful in anticipating and preventing problems with the present pregnancy.

8. **Newborn weight** (in grams or pounds and ounces). This information may give indications of gestational diabetes, fetal growth problems, shoulder dystocia, or cephalopelvic disproportion

. 9**. Newborn gender**. This may provide insight into patient and family expectations and may indicate certain genetic risk factors.

10**. Fetal and neonatal complications.** Certain questions should be asked to elicit any problems and to determine the need to obtain further information. Inquiry should be made as to whether the baby had any problems after it was born, whether the baby breathed and cried right away, and whether the baby left the hospital with the mother. MENSTRUAL HISTORY A good menstrual history is essential because it is the determinant for establishing the expected date of confinement (EDC). A modification of Nägele's rule for establishing the EDC is to add 9 months and 7 days to the first day of the last normal menstrual period (LMP). For example: LMP: July 20, 2008 EDC: April 27, 2009 This calculation assumes a normal 28-day cycle, and adjustments must be made for longer or shorter cycles. Any bleeding or spotting since the last normal menstrual period should be reviewed in detail and taken into account when calculating an EDC. CONTRACEPTIVE HISTORY This information is important for risk assessment. Oral contraceptives taken during early pregnancy have been associated with birth defects, and retained intrauterine

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CONTRACEPTIVE HISTORY This information is important for risk assessment. Oral contraceptives taken during early pregnancy have been associated with birth defects, and retained intrauterine devices (IUDs) can cause early pregnancy loss, infection, and premature delivery. MEDICAL HISTORY The importance of a good medical history cannot be overemphasized. In addition to common disorders, such as diabetes mellitus, hypertension, and renal disease, which are known to affect pregnancy outcome, all serious medical conditions should be recorded.

SURGICAL HISTORY Each surgical procedure should be recorded chronologically, including date, hospital, surgeon, and complications. Trauma must also be listed (e.g., a fractured pelvis may result in diminished pelvic capacity).

SOCIAL HISTORY Habits such as smoking, alcohol use, and other substance abuse are important factors that must be recorded and managed appropriately. The patient's contact or exposure to domesticated animals, particularly cats (which carry a risk for toxoplasmosis), is important. The patient's type of work and lifestyle may affect the pregnancy. Exposure to solvents (carbon tetrachloride) or insulators (polychlorobromine compounds) in the workplace may lead to teratogenesis or hepatic toxicity

Gynecologic History A full history is equally as important in evaluating the gynecologic patient as in evaluating a patient in general medicine or surgery. The history-taking must be systematic to avoid omissions, and it should be conducted with sensitivity and without haste.

PRESENT ILLNESS The patient is asked to state her main complaint and to relate her present illness, sequentially, in her own words. Pertinent negative information should be recorded, and as much as possible, questions should be reserved until after the patient has described the course of her illness. Generally, the history provides substantial clues to the diagnosis, so it is important to evaluate fully the more common symptoms encountered in gynecologic patients.

Abnormal Vaginal Bleeding Vaginal bleeding before the age of 9 years and after the age of 52 years is cause for concern and requires investigation. These are the limits of normal menstruation, and although the occasional woman may menstruate Chapter 2 Clinical Approach to the Patient 15 regularly and normally up to the age of 57 or 58 years, it is important to ensure that she is not bleeding from uterine cancer or from exogenous estrogens. Prolongation of menses beyond 7 days or bleeding between menses, except for a brief kleine regnen at ovulation, may connote abnormal ovarian function, uterine myomas, or endometriosis

. **Abdominal Pain** Many gynecologic problems are associated with abdominal pain. The common gynecologic causes of acute lower abdominal pain are salpingo-oophoritis with peritoneal inflammation, torsion and infarction of an ovarian cyst, endometriosis, or rupture of an ectopic pregnancy. Patterns of pain radiation should be recorded and may provide an important diagnostic clue. Chronic lower abdominal pain is generally associated with endometriosis, chronic pelvic inflammatory disease, or large pelvic tumors. It may also be the first symptom of ovarian cancer.

Amenorrhea The most common causes of amenorrhea are pregnancy and the normal menopause. It is abnormal for a young woman to reach the age of 16 years without menstruating (primary amenorrhea). Pregnancy should be suspected in a woman between 15 and 45 years of age who fails to menstruate within 35 days from the first day of her last menstruation. In a patient with amenorrhea who is not pregnant, inquiry should be made about menopausal or climacteric symptoms such as hot flashes, vaginal dryness, or mild depression.

Other pertinent symptoms of concern include dysmenorrhea, premenstrual tension, fluid retention, leukorrhea, constipation, dyschezia, dyspareunia, and abdominal distention. Lower back and sacral pain may indicate uterine prolapse, enterocele, or rectocele.

MENSTRUAL HISTORY The menstrual history should include the age at menarche (average is 12 to 13 years), interval between periods (21 to 35 days with a median of 28 days), duration of menses (average is 5 days), and character of the flow (scant, normal, heavy, usually without clots). Any intermenstrual bleeding (metrorrhagia) should be noted. The date of onset of the LMP and the date of the previous menstrual period should be recorded. Inquiry should be made regarding menstrual cramps (dysmenorrhea); if present, the age at onset, severity, and character of the cramps should be recorded, together with an estimate of the disability incurred. Midcycle pain (mittelschmerz) and a midcycle increase in vaginal secretions are indicative of ovulatory cycles.

CONTRACEPTIVE HISTORY The type and duration of each contraceptive method must be recorded, along with any attendant complications. These may include amenorrhea or thromboembolic disease with oral contraceptives; dysmenorrhea, heavy bleeding (menorrhagia), or pelvic infection with the intrauterine device; or contraceptive failure with the diaphragm, contraceptive sponge, or contraceptive cream.

OBSTETRIC HISTORY Each pregnancy and delivery and any associated complications should be listed sequentially with relevant details and dates.

SEXUAL HISTORY The health of, and current relationship with, the husband or partner(s) may provide insight into the present complaints. Inquiry should be made regarding any pain (dyspareunia), bleeding, or dysuria associated with sexual intercourse. Sexual satisfaction should be discussed tactfully.

PAST HISTORY As in the obstetric history, any significant past medical or surgical history should be recorded, as should the patient's family history. A list of current medications is important.

SYSTEMIC REVIEW A review of all other organ systems should be undertaken. Habits (tobacco, alcohol, other substance abuse), medications, usual weight with recent changes, and loss of height (osteoporosis) are important parts of the systemic review.

Summary

1-General information: name, age, gravidity and parity

2-Current problem/ complaint

3-History of current complaint

4-History of current pregnancy

5-Menstrual & gynecological history: LMP details regularity, length of the cycle, OCP , STD , dysmenorrhea etc ..

6-Past obstetric history

7-Past medical/ surgical Hx DM , HTN, epilepsy

8- Drug Hx and contraceptive Hx

9- Family Hx Hereditary diseases etc …

10-Social Hx smoking animal exposure etc…

For mistakes or feedback

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