

HISTORY TAKING & PHYSICAL EXAMINATION OB/GYN

DR. GHADEER ALSHAIKH
ASSOCIATE PROFESSOR

OBSTETRIC HISTORY

General information

History of current pregnancy

Past Obstetric history

Gynecological history

Enquiry about other systems:

Past medical and surgical history

Psychiatric history

Family history

Social history

Drug history

Allergies

Summary

OBSTETRIC HISTORY

◉ General information

- Name
- Age
- Presenting complaint (patients words not medical words) or reason for attending.

◎ History of current pregnancy

➤ Gravidity

➡ The total numbers of pregnancies regardless of how they ended.

➤ Parity

➡ number of live births at any gestation or stillbirths after 24 weeks of gestation

➤ Gestation (GA)

➤ LMP (last menstrual period)

➤ EDD “Expected date of delivery” (Naegele’s rule)

➡ Add 7 days to the first day of LMP , subtract 3 months , add one year

➡ Example : LMP 27 /8/2014

➡ EDD : 3/6/2015

- Dates as calculated from ultrasound
- Single /multiple (chorionicity)
- Detailed of presenting problem
- Have there been any other problems in this pregnancy ?
- Has there been any bleeding , contractions or loss of fluid vaginally ?

◎ Past Obstetric history :

- List the previous pregnancies and their outcomes in order

◎ Gynecological history :

- Periods: regularity
- Contraceptive history
- Previous infections and their treatment
- When was the last cervical smear? Was it normal? Have there ever been any that were abnormal? If yes, what treatment has been undertaken ?
- Previous gynecological surgery ?

○ Past medical and surgical history:

- Relevant medical problems
- Any previous operations; type of anesthetic used, any complications

○ Psychiatric history :

- Post partum blues or depression
- Depression unrelated to pregnancy
- Major psychiatric illness .

◉ Family history :

- Diabetes ,hypertension, thromboembolic disease , genetic problems, psychiatric problems ...

◉ Social history:

- Smoking, illegal drug used
- Marital status
- Occupation

◉ Drug history

◉ Allergies

◉ Summary

OBSTETRICS PHYSICAL EXAMINATION

General examination

Abdominal examination

Lower limb examination

Pelvic examination

OBSTETRICS PHYSICAL EXAMINATION

◎ General exam

- Weight
- Height
- BMI ➡ (weight (kg) / Height (m²))
- Vital signs (blood pressure , pulse , respiratory rate , temperature)
- Cardiovascular examination (routine auscultation for maternal heart sounds in asymptomatic women with no cardiac history is unnecessary).
- Breast examination (Formal breast examination is not necessary, self examination is as reliable as a general physician examination in detecting breast masses.)

ABDOMINAL EXAM

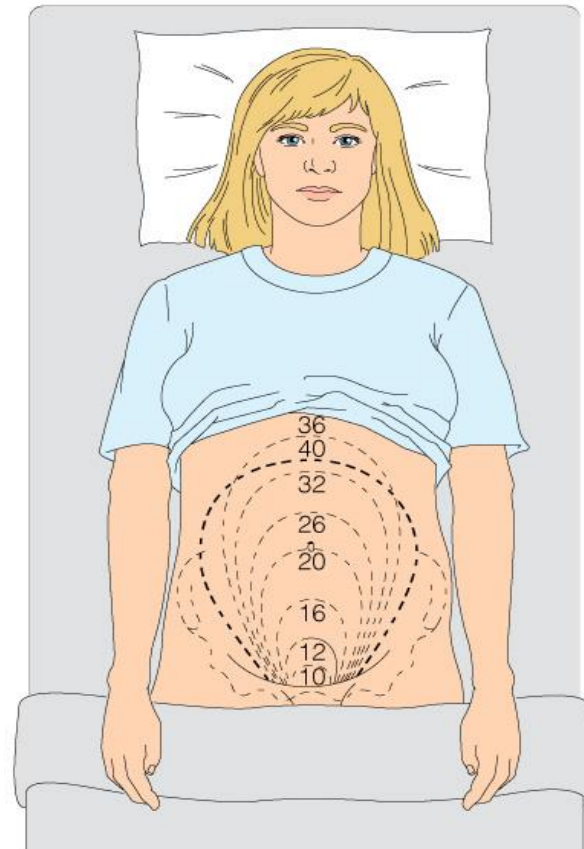
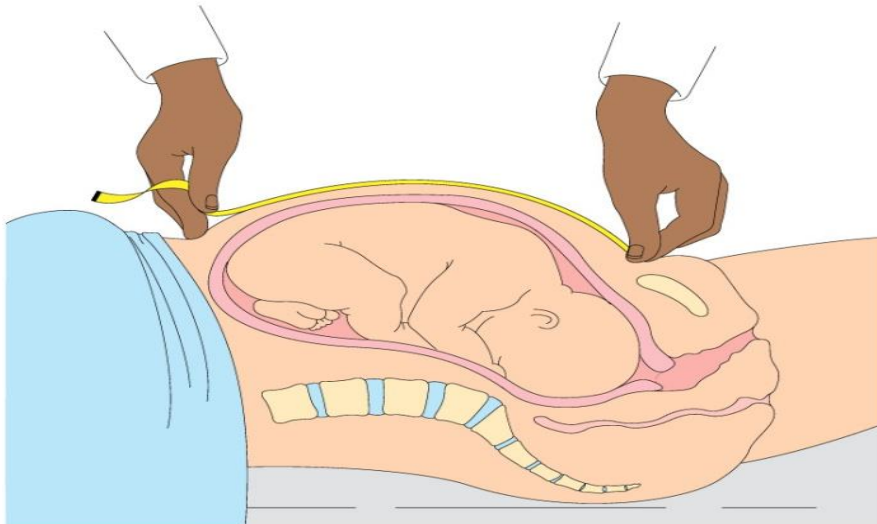
- Ask about areas of tenderness before start the examination.
- Inspection
 - ➔ Assess shape of the uterus
 - ➔ Note any asymmetry
 - ➔ Look for fetal movement
 - ➔ Look for surgical scars
 - ➔ cutaneous signs of pregnancy ➔ linea nigra, striae gravidarum, striae albicans, umbilicus flat or everted, superficial veins



ABDOMINAL EXAM

➤ Palpation

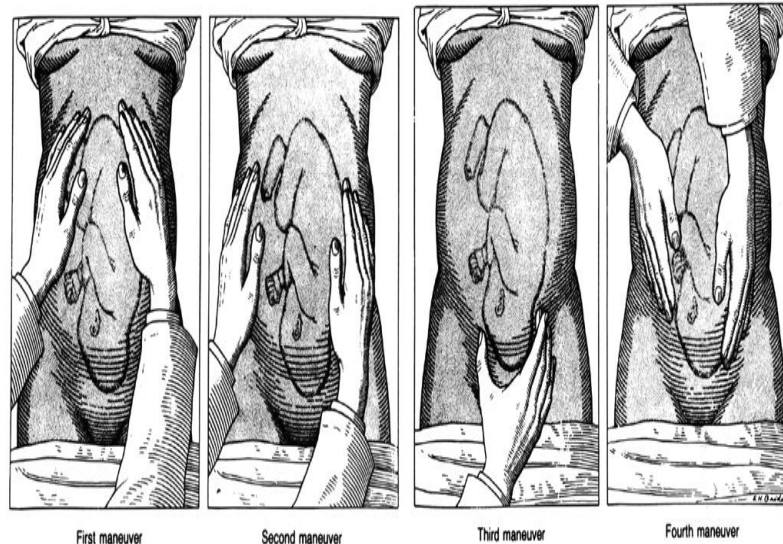
- Uterine size ➔ symphysis fundal height in cm = GA in wks
 - at 12-14 wks ➔ just palpable
 - 20-22 wks ➔ at the umbilicus



ABDOMINAL EXAM

◉ LEOPOLD maneuvers

- ◉ **The first maneuver (fundal grip):** involves palpating the fundus to determine which part of the fetus occupies the fundus
- **The second maneuver (Lateral grip):** involves palpating the either side of the abdomen to determine on which side the fetal back lies.
- **The third maneuver (Pawlick's grip) :** involves grasping the presenting part between the thumb and third finger just above the pubic symphysis to determine what fetal part is lying above the pelvic inlet or lower abdomen.
- **The fourth maneuver (Pelvic grip):** involves palpating for the brow and the occiput of the fetus determine the fetal position when the fetus is in a vertex presentation.



FETAL LIE, PRESENTATION AND ENGAGEMENT

- Lie of the fetus ➔ longitudinal axis of the uterus to the longitudinal axis of the fetus (e.g. longitudinal, transverse, oblique).
- Presentation ➔ the part of the fetus that overlays the pelvic brim (e.g. vertex, breech, shoulder).
- Engagement : occurred when the widest part of the presenting part has passed successfully through the pelvic inlet.



Longitudinal lie
Vertex presentation



Longitudinal lie
Breech presentation



Transverse lie
shoulder presentation

DESCENT OF THE FETAL HEAD

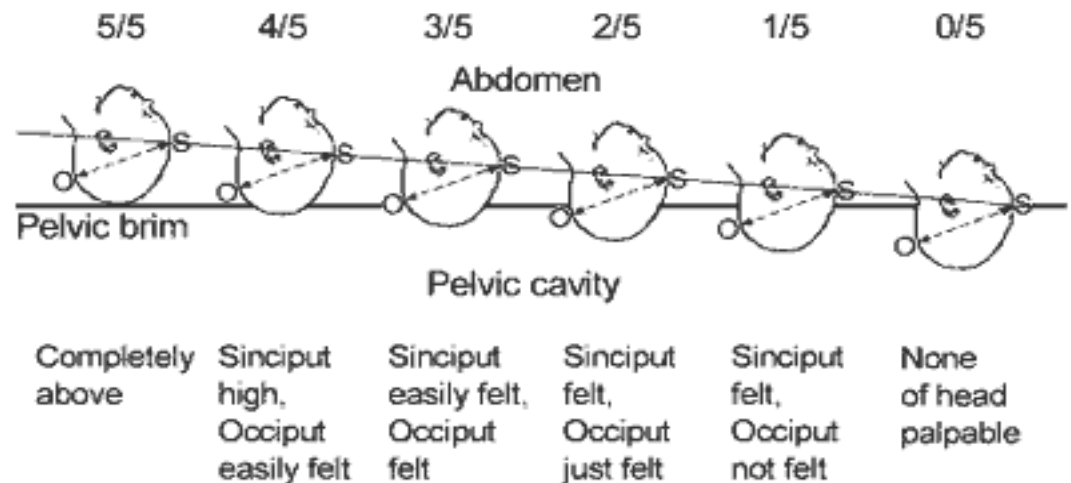
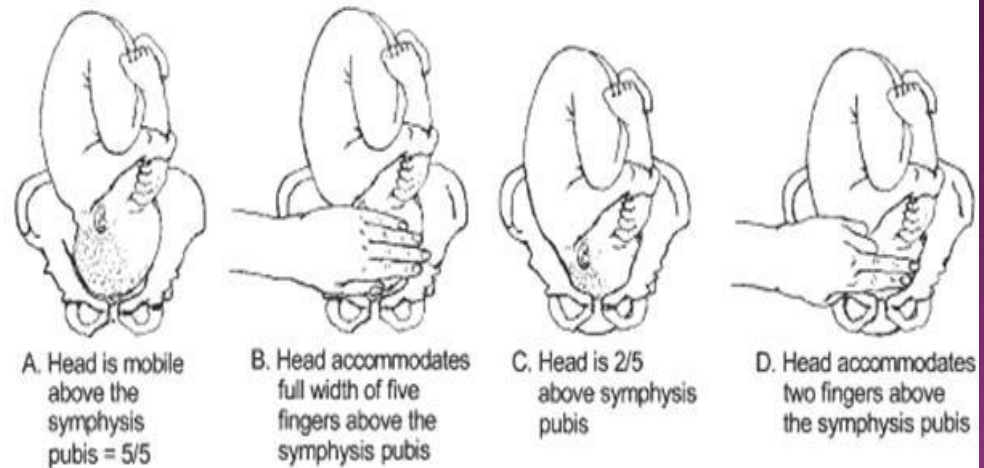
- ❖ Assessed abdominally
- ❖ Using the rule of fifth to assess the engagement

→ Assess how much of the head

is still felt per abdomen

- ❖ When only 2/5 or less of the fetal head palpated above the level of symphysis pubis, this implies the head is engaged

→ The vertex has passed or the level of ischial spines



ABDOMINAL EXAM

➤ **Ascultation**

Listening for the fetal heart beat.



LOWER LIMBS EXAMINATION

- Swelling (edema)
- Varicosities

PELVIC EXAMINATION

- Routine pelvic examination is not necessary.
- Circumstances in which a vaginal examination is necessary (in most cases a speculum examination is all that is needed), these include :
 - Excessive or offensive discharge
 - Vaginal bleeding (in the known absence of a placenta previa).
 - To perform a cervical screen
 - To confirm potential rupture of membrane

PELVIC EXAMINATION

- *A digital examination may be performed:*
- *when an assessment of the cervix is required . This can provide information about the consistency and effacement of the cervix that is not obtainable from a speculum examination (Modified Bishop score).*

Score	Cervical Dilation	Cervical Effacement	Station of Baby	Cervical Position	Cervical Consistency
0	closed	0-30%	-3	posterior	firm
1	1-2cm	40-50%	-2	mid-line	moderately firm
2	3-4cm	60-70%	-1,0	anterior	soft (ripe)
3	5+ cm	80+%	+1, +2		

PELVIC EXAMINATION

- *The contraindication to digital examination are :*
- ❑ Known placenta previa or vaginal bleeding when the placental site is unknown and the presenting part unengaged
- ❑ Prelabor rupture of the membranes (increased risk of ascending infection).

GYNECOLOGIC HISTORY

General information

History of present complaint (e.g, pelvic pain, vaginal discharge).

Menstrual history

Previous gynecological history

Previous obstetrics history

Enquiry about other systems

Past medical and surgical history

Psychiatric history

Family history

Social history

Drug history

Allergies

Summary

GYNECOLOGIC HISTORY

◉ General information

- Name
- age
- Main complaints

◉ History of present complaint

- The detailed questions relating to each complaint.

GYNECOLOGIC HISTORY

- ◉ Pelvic pain

- Site of pain , its nature and severity
- Any thing that aggravates or relieves the pain-specifically enquire about relationship to menstrual cycle and intercourse
- Does the pain radiate anywhere or is it associated with bowel or bladder function

◎ Vaginal discharge

- Amount, colour, odour, presence of blood
- Relationship to menstrual cycle
- Any history of sexually transmitted disease or recent tests
- Any vaginal dryness

GYNECOLOGIC HISTORY

◉ Menstrual history:

- Age of menarche
- Usual duration of each period and length of cycle
- First day of the last period
- Pattern of the bleeding : regular or irregular and length of the cycle
- Amount of blood loss : more or less than usual, number of sanitary towels or tampons used , passage of clots or flooding
- Any intermenstrual or postcoital bleeding
- Any pain relating to the period, its severity and timing of onset
- Any medication taken during the period

◎ Previous gynecological history :

- Previous treatment and surgery
- Date of the last cervical smear and any previous abnormalities
- Sexual active , difficulties or pain during intercourse
- The type of contraception used and any problem with it
- Menopause:(Date of last period ,any post menopausal bleeding ,any menopausal symptoms)

GYNECOLOGIC HISTORY

- Previous obstetrics history

- Outcome & details of previous pregnancies

- Enquiry about other systems:

(e.g,Appetite, weight loss/gain, bowel function, bladder function)

- Past medical & surgical history

- Psychiatric history

- Family history

- Social history

- Drug history

- Allergies

- Summary

GYNECOLOGIC PHYSICAL EXAMINATION

General examination

Abdominal examination

Pelvic examination

Rectal examination

GYNECOLOGIC PHYSICAL EXAMINATION

- ◉ General exam :

- Height
- Weight , BMI
- Vital signs
- Hands , mucous membrane
- Supraclavicular area
- Thyroid
- Chest (CVS ,Respiratory)
- Breast

⊙ Abdominal exam

1-Inspection

- ➡ distension ➡ masses
- ➡ surgical scars
- ➡ hernia

2-Palpation

- ➡ guarding ,
tenderness,
masses

3-Percussion :

useful if free fluid is suspected

4-Auscultation:

not specifically useful for the gynecological examination
, in case of acute abdomen with bowel obstruction or
postoperative patient with ileus (listening of bowel sounds)

⊙ Pelvic examination

➤ *Inspection:*

- External genitalia and surrounding skin

➤ *Speculum (bivalve , Or Cusco)*



SPECULUM EXAMINATION – Note that speculum in illustration is not a Cusco....

Sample Use Only - Copy

Sample Use Only - Copy

Sample Use Only - Copy

Sample Use Only - Copy

Sample Use Only - Copy

Inspect the cervix:

- Type of cervical os- small round dimple (nulliparous os) or os in the shape of a smile (multiparous os)
- Colour- normally pink, may be a redder area around the os, known as cervical ectropion, or tinged blue if pregnant, red in cervicitis
- Secretions/ discharge - observe colour (eg cervical mucus if ovulating, blood if menstruating)
- Presence of growths/ tumours- usually cauliflower-like and friable, i.e. bleeds on touch (indicates malignancy)
- Ulcerations, scars and retention cysts (Nabothian follicles)
- The cervical smear/"Pap" smear is taken at this stage

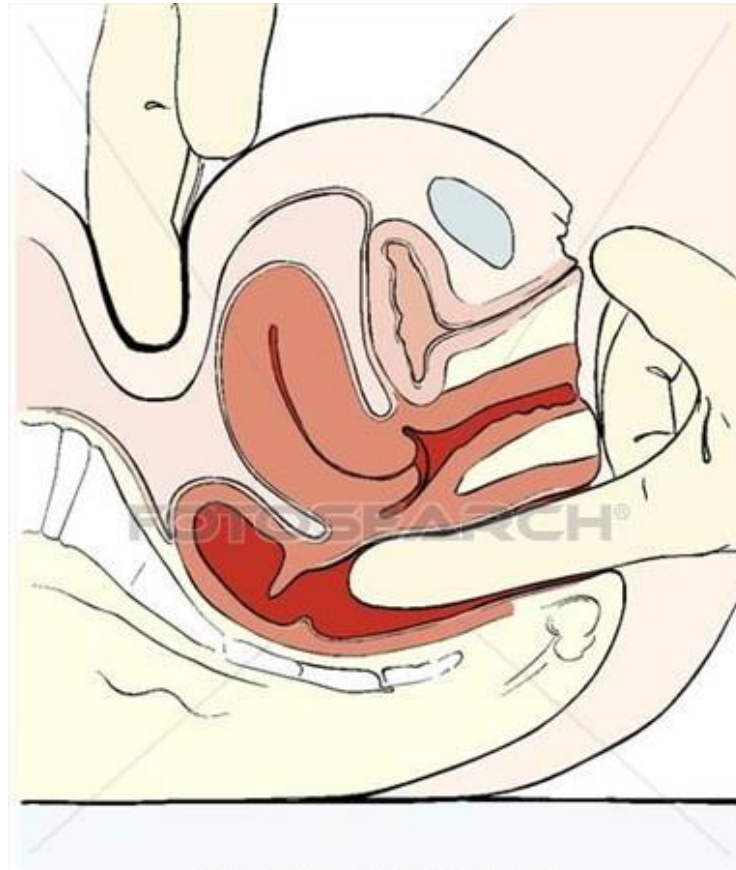
Sample Use Only - Copy

Sample Use Only - Copy

➤ *Bimanual examination*

⦿ **Rectal examination:**

➤ Used as alternative to a vaginal examination in children and in adults who are not sexually active.



Thank You