History taking

in

obstetrics and gynecology

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What is a history

It is a full story taken from the patient including whole her personal , social and health information concentrating on present problem

The history is usually taken in the patient language and we explain it in a way that we can reach to her real problem or diagnosis .

Aim of the history

Is to reach to the diagnosis of the disease the patient suffer from so we can manage her correctly and perfectly

Steps of the history

1-name

2-age

3-occupation

4-address

5-next of kin

6-marital status

7-blood group and Rh group

Gravida ⟶ only in a pregnant patient

It refers to number of living babies the patient have + number of dead babies + number of abortions + the present pregnancy .

Parity :number of living babies + number of dead babies (> 20 weeks gestation) then we add number of abortions (20 weeks and less)

e.g : if the patient is pregnant and have 6 children and 2 abortion → G 9 P6 + 2

And if she is not pregnant P6+2

LMP

(last menstrual period)

Refers to the date of the last time the patient had her cycle

EDD

(expected date of delivery)

Only in pregnant

It is the time we expect delivery to occur in pregnant patient calculated from her LMP by adding 9 months + 7 days

e.g : LMP 14-1-2018

21 -10-2018

e.g LMP 27-7-2018

4-5-2019

POA (period of amenorrhea)

It is the period that the patient had no menstrual cycle and calculated from LMP and the current date - every 2 months = 9 weeks

every 3 months = 13 weeks

Note: months of pregnancy = 9 months = 40 W

e.g/ LMP 5-2-2018

POA= 28 weeks +4days

Date of admission

Chief complaint and duration

Chief complaint is the chief illness make the patient come to hospital or clinic

e.g: vaginal bleeding, abdominal pain, loin pain, dysuria.....

History of present illness

The condition started few hours or few days before admission as e.g pain → describe it

1- site

2- severity

3- nature

4- duration

5-associated factors

6- relieving factors

7- aggravating factors

8- Radiation

e.g2

Vaginal bleeding

Severity

Associating

Relieving factors

Then --- continue the history and you must concentrate on every small information that you regard it as important and have relation with present illness, every investigation and treatment and proceed in history until reaching the date of admission (you must describe it thoroughly)

In post operative patient

Must start like this

↓

Chief complaint

1st or 2nd post op patient for elective or emergency op

(mention the name of OP – **Caesarean section** , curettage , hysterectomy, laprotomy)

History of present illness : patient is now in her 1st post operative day for c/s because of(e.g breech presentation or because of previous 2 c/s) , she had good antenatal care in her pregnancy

Divide pregnancy into three trimesters

T1 first three months of pregnancy

Nausea , vomiting , hyperemesis gravidarum, pain, V – bleeding, V discharge, any ANC, investigations, drugs, admission

T2 :

1- Quickening

first fetal movement felt by the pregnant woman

Normally

in primigravida at 18-20 weeks

in multigravida at 16-18 weeks

2- Events (pain , V bleeding, trauma)

3-Any investigations.

4-Any treatment.

5- Admission to hospital.

T3

Any events

FM

Investigations

Treatment

etc…..

Then you mention the cause of Cs , if emergency you must start from date of admission to labour room and proceed one of events that occur there until you reach to the cause that made her not to deliver vaginally

Like : 1-VB (APH)

2-FTP(failure to progress)

3-Fetal distress

4- Any other cause

if elective---

Elective means the patient have ANC prepared for operation by her doctor for any cause like :

Previous operation or abnormal presentation

etc….

You reach to the date of admission

Here you must mention every action done for her at that day by the doctor

i.e preoperative investigations

Blood preparation

Then the time of admission to OP room

Time of staying there

Her situation at discharge from OP room

(conscious level, orientation, pain, VB)

Her situation at obstetric ward and any action done for her in the ward

(input , output), drugs .

1st Post operative day

Removal of catheter

Removal of IV fluid

Starting oral intake

Pain

VB

Other complain

ROS

Past history

Medical history ,

surgical history ,

gynecological history =

Menarche

Dysmenorrhea (primary or secondary)

Regularity of the cycle

Dysparonhoea

Contraception

Past obstetric history

Date of marriage

Period of primary infertility

Parity

Pregnancy out come

Delivery condition

Any event at puerperium

Baby (if any handicapped baby she have)

Family history

Social history

Drug history

Thank you