BIODATA
PRESENTING COMPLAINTS
HISTORY OF PRESENTING COMPLAINTS
MENSTRUAL HISTORY
MENOPAUSAL HISTORY (IF APPLICABLE)
PAST GYNECOLOGICAL HISTORY
PAST OBSTETRIC HISTORY
SEXUAL HISTORY
MEDICATIONS AND ALLERGIES
FAMILY HISTORY
SOCIAL HISTORY AND LIFESTYLE
SYSTEMIC REVIEW
SUMMARY

BIODATA

Name of patient
Age
Sex
Address
Tribe
Religion
Marital status
Occupation

The process of taking a history in OB/GYN patients presents unique challenges. Because of the intimate aspect of an OB/GYN examination, it is important to establish trust and a private and relaxing setting for the patient. This article provides an overview of the possible content of the H&P of the OB/GYN patient. Depending on the patient's symptoms, additional and/or more targeted questions may also be relevant.

General principles
A key difference in OB/GYN history taking is the focus on the menstrual/menopausal history and sexual history.
Patients may be hesitant to disclose certain aspects of their gynecologic history because of the sensitive nature of the topic. In some cases, it may be due to cultural differences or even a history of abuse.
Be empathetic and try to create a comfortable environment for each of your patients, since it will encourage them to discuss matters more openly with you.
If you feel that the patient is uncomfortable talking about their gynecologic history, start with a social or family history in order to establish rapport with the patient.

Gynecologic history
Chief concern and history of present illness

Begin with a brief summary of the patient's age, parity, date of last menstrual period (LMP), and any current concerns the patient may have.
Common chief concerns in gynecology

1. Vaginal bleeding should be evaluated based on the following:

Amount (e.g., spotting, heavy flow)
Relation to menstrual cycle/menopause/sexual contact (e.g, intermenstrual, postmenopausal, postcoital)
Overview of causes of vaginal bleeding in different age groups

1. Premenarchal children

Estrogen withdrawal (in neonates)
Precocious puberty
Trauma
Tumors (e.g., sarcoma botryoides)
Foreign bodies
Vulvovaginitis

2. Nonpregnant women

Abnormal uterine bleeding
Uterine leiomyoma
Adenomyosis
Endometriosis
Endometrial hyperplasia
Endometrial polyps
Pelvic inflammatory disease
Polycystic ovary syndrome
Endocrine disorders (e.g., hypothyroidism, hyperprolactinemia)
Coagulopathies (e.g., von Willebrand disease)
Genitourinary trauma

3. Pregnant women

Ectopic pregnancy
Spontaneous abortion
Antepartum hemorrhage
Placental abruption
Placenta previa
Uterine rupture
Trauma in pregnancy

4. Postmenopausal women

Gynecologic malignancies (e.g., cervical or endometrial cancer)
Benign proliferative disorders
Endometriosis
Endometrial hyperplasia

Endometrial polyps
Uterine leiomyoma
Hormone replacement therapy
Atrophic vaginitis
Endocrine disorders (e.g., hypothyroidism

Overview of differential diagnoses of painful vaginal Bleeding

Differential Diagnoses	Description of Pain	Other clinical features	Diagnostic Findings
Ectopic Pregnancy	Lower unilateral abdominal pain and guarding	Amenorrhoea	Ultrasound: may show echogenic mass in the tube or cervix Positive pregnancy
Spontaneous Abortion	Cramping abdominal-pelvic pain	Vaginal bleeding Fever, purulent vaginal discharge, ↑ HR, ↓ BP in septic abortion	Ultrasound: disappearance of previously detected embryonic cardiac activity ↓ ß-hCG Open cervical os in incomplete abortion
Benign Neoplasms (**Adenomyosis & Uterine Leiomyoma)**	Adenomyosis:Chronic pelvic pain Uterine Leiomyoma:Back or pelvic pain/discomfort	Adenomyosis: Uniformly enlarged uterus Uterine Leiomyoma: Irregularly enlarged Uterus **<u>IN BOTH</u>** Menorrhagia Dysmenorrhea Infertility	Adenomyosis Ultrasound: may show asymmetric myometrial wall thickening and myometrial cysts Uterine Leiomyoma Ultrasound: may show hypoechoic, heterogeneous tumors
Ovarian Cyst Rupture	Sudden onset of unilateral abdominal pain	Onset usually during physical activity (exercise, sexual intercourse)	Ultrasound: may show pelvic free fluid and/or adnexal mass
Infection/inflammation ● Pelvic Inflammatory Disease	● Lower bilateral abdominal	Fever Menorrhagia Metrorrhagia	Ultrasound: may show free fluid, abscesses,

	pain	Dyspareunia Purulent cervical discharge	pyosalpinx/hydrosalpinx Cervical and urethral swab: positive PCR and cultures for Neisseria gonorrhoeae and/or Chlamydia trachomatis
• Cervicitis	• Lower abdominal pain Pelvic pain	Intermenstrual bleeding Vaginal discharge Dyspareunia Usually no fever	Cervical swab: positive PCR and cultures for N. gonorrhea and/or C. trachomatis
Endometriosis	Chronic pelvic pain that worsens before the onset of menses	Dysmenorrhea Premenstrual or postmenstrual bleeding Dyspareunia Infertility	Ultrasound: may show ovarian cysts and/or nodules in the bladder or rectovaginal septum Laparoscopy: endometriotic implants and adhesions
Trauma (e.g., foreign body, sexual abuse)	Pelvic Pain	Bruising Hematoma (possible accompanying injuries)	Depends on the type and mechanism of trauma

2. Vaginal Discharge. Vaginal discharge should be evaluated based on the following:
Color (e.g., bloody, brown, yellow, green, or gray)
Consistency (e.g., frothy, curd-like)
Amount
Smell (e.g., fishy)
A lot of patients confuse normal cervical mucus with pathological vaginal discharge so make sure to collect a thorough description of the discharge.

3.Pruritic and/or Erythematosus Vagina

4.Abdominal or pelvic pain, that can be described using the SOCRATES mnemonic:
Site
Onset
Character

Radiation
Associations
Time course
Exacerbating and relieving factors
Severity

MENSTRUAL HISTORY
Age at menarche
Date of last menstrual period (LMP)
Duration, regularity, flow and associated symptoms (e.g., dysmenorrhea, mittelschmerz)
History of intermenstrual vaginal bleeding

Menopausal history (if applicable)
Age at onset
History of postmenopausal uterine bleeding
Associated symptoms (e.g., vasomotor symptoms like
Increased **sweating**

- **Hot flashes**
- **Heat intolerance**

Genitourinary syndrome of menopause (GSM) - Vulvovaginal atrophy leading to:
Vaginal dryness
Dyspareunia
Decreasing labial fat pad
Pruritus

Lower urinary tract atrophy leading to:
Dysuria
Urinary frequency and/or urgency
Urinary incontinence

Neuropsychiatric Symptoms like Impaired sleep (e.g., from insomnia and/or night sweats)
Anxiety/irritability
Mood swings or depression [7]
Vertigo

History of hormone replacement therapy

Past gynecologic history
Previous gynecologic problems (including diseases of the breast)
Previous gynecologic/pelvic surgeries (e.g., cervical conization, hysterectomy)

History of sexually transmitted infections and/or pelvic inflammatory disorder
Time and results of previous screening/diagnostic tests (e.g., Pap smear, mammography)

Past obstetric history
Obstetric history taking varies based on the setting (normal prenatal checkup vs. patient presenting with a concern).
Past obstetric history (GTPAL system)
Gravida: number of times the patient has conceived
Term pregnancies (≥ 37 weeks of gestation)
Mode of delivery (e.g., normal spontaneous vaginal delivery/NSVD)
Birth weight/gender of the baby
Maternal/fetal perinatal complications
Use of assisted reproductive therapies
Preterm pregnancies (< 37 weeks of gestation)
Abortions (elective or spontaneous before 20 weeks gestation….Including ectopic pregnancies)
Living children or live births

Current pregnancy
Gestational age and expected day of delivery
Beginning of prenatal care (e.g, use of folate, regular OB/GYN visits)
History of teratogenic drug use
History of maternal infectious diseases and immunization; See “Congenital TORCH infections” for more information.
Prenatal diagnostic results (e.g., previous ultrasound findings)
History of vaginal bleeding or fluid leakage during the current pregnancy
Presence and frequency of fetal movement and uterine contractions
Any other presenting complaints.
If the mother is not aware of previous perinatal complications, try asking her how soon she went home with the baby after the delivery.

Sexual history
Opening the discussion
Discussing a patient's health is often a sensitive matter. It is important to encourage the patient to be as descriptive as possible while remaining sensitive to the fact that they are sharing very private details of their life. Always remain empathetic and open to discussion.
If the patient seems hesitant, explain to them that this information is vital for forming an overall picture of their health and that it is as important as other aspects of their physical and mental health
Current/past sexual partners
Discussing the patient's current/past sexual partners is an important part of taking a patient's sexual history.
The following questions can be used:

“Are you currently sexually active? If not, have you ever been sexually active?”
“In recent months, how many sex partners have you had? In the past 12 months, how many sex partners have you had?”
“Are your sex partners men, women, or both?”: If a patient answers “both,” repeat the first two questions for each specific gender.
Current/past sex practices
It is necessary to ask about the patient's sexual practices to determine if they have risk factors for STIs, whether they need testing, and to guide a discussion regarding risk-reduction strategies.
Example: “I am going to ask you a few questions to better understand if you are at risk for STIs. What kind of sexual contact do you usually engage in (genital/oral/anal)?”
Current/past contraception methods use
This part of sexual history is particularly important since the use of barrier contraceptive methods can significantly reduce one's risk of STIs. Therefore, collecting this information can be very helpful in terms of assessing one's risk of developing an STI.
Example: “Do you and your partner(s) practice any form of birth control?”
If not, ask them why not.
If yes, ask them which method of contraception they use and with what frequency.
If the patient is sexually active, be sure to ask them if they are trying to conceive. If so, ask (how long they've been trying and) if they are experiencing any difficulties.
Always give the patient the chance to ask questions about their sexual health including different types of contraception, their indications, contraindications, as well as the potential for STI transmission , and the benefit of using barrier contraceptive methods as an STI prophylaxis method.

History of STIs
A history of STIs should cover the patient's previous diagnoses and/or treatments of STIs, the presence of recurrent symptoms, as well as past STI testing results.
The following questions can be used:
“Have you ever been diagnosed with an STI? When? What treatment did you receive?”
“Have you ever been tested for HIV, or other STIs? Would you like to be tested?”
“Has your current partner or any former partner ever been diagnosed or treated for an STI? Were you tested for the same STI(s)? If yes, when were you tested? What was the diagnosis? How was it treated?”

History of postcoital vaginal bleeding
History of sexual dysfunction (e.g., dyspareunia, low libido)
History of sexual abuse
Transgender individuals receiving gender-affirming hormone therapy are still at risk of unintended pregnancy

Note: The **5 Ps** of a sexual history include **P**artners, **P**ractices, **P**rotection from STIs, **P**ast history of STIs, and **P**revention of pregnancy

Medications and allergies

- Prescribed drugs
- Over-the-counter drugs
- Herbal remedies
- Allergies to drugs or environmental factors and reaction to each allergen

Enzyme-inducing medications like rifampicin, some antiepileptic drugs, some antiretrovirals, and St John's wort can reduce the efficacy of hormonal contraception. [1][2]

Family history
Cancers of the reproductive system in the family (e.g., breast cancer and ovarian cancer with BRCA1/2 gene mutations)
Endocrine disorders (e.g., diabetes mellitus, hypertension)

SOCIAL HISTORY
Relationship status
Socioeconomic status
Occupation
Drug and alcohol use

Review of Systems In the OB/GYN examination, a particular emphasis should be placed on the:
Urogenital system (e.g., dysuria, hesitancy, urgency, incontinence, change in bowel habits, rectal bleeding)
Abdomen (e.g., abdominal/pelvic pain)
Breasts
For post/perimenopausal women, it is important to ask about menopausal symptoms (e.g., hot flashes/night sweats, vaginal dryness, abnormal bleeding, irritability, depression, mood changes).

If you feel that the patient is not comfortable talking about their gynecologic history, start with social/family history in order to establish rapport with the patient.

Summary Summarizing an obstetrics-gynecology (ob-gyn) report involves extracting key information while maintaining clarity and conciseness. Here's a structured approach:

Conclusion
- A brief wrap-up highlighting the overall status and next steps.

Example Summary
Patient: J.D., 28 years old
Reason for Visit: Routine check-up; concerns about irregular periods.
Clinical Findings: Normal pelvic exam, ultrasound shows no abnormalities.
Assessment: Possible hormonal imbalance.
Plan: Start on hormonal therapy, return in 3 months for follow-up.
Conclusion: J.D. is to monitor symptoms and follow the treatment plan.

This structured approach ensures that the summary is informative and easy to understand.