OBSTETRIC HISTORY AND EXAM

A.) **History**

Demographics/Introduction

- Name
- Age
- Residence
- Occupation
- Marital status
- Gravidity and Parity
  Gravida denotes pregnant state both present and past regardless of outcome.
  5 or more births are called grand multipara.
  Parity number of **previous** pregnancies beyond period of viability.
  Nullipara –never completed pregnancy beyond viability. May or not have aborted previously
  Nulligravida-not and never been pregnant
  Primipara-one who has delivered one viable child
  Primigravida-one who is pregnant for the first time
- Gestational age (How old the pregnancy is from the woman's LNMP)
- Religion
- Referral?

CHIEF COMPLAINT

e.g., Per Vaginal Bleeding

HISTORY OF PRESENTING COMPLAINT (Exhaust Chief complaint if the client has any)
If referred, by whom? Relate history to gestational age. By direct questioning seek history of hypertension, bleeding, draining, contractions, mucous, 'show', and fetal movements (

SYSTEMIC ENQUIRY

Present relevant system with history of present complaint and then briefly other systems.

HISTORY OF PRESENT PREGNANCY

Menstrual History

Last normal menstrual period (LNMP). Certainty of LNMP (sure or unsure dates). Any subsequent bleed. Brief details of cycle frequency, duration (3 to 7 days) and quantity of loss (use number of pads-normal is 3 to 5 pads) – this is more relevant in a gynaecological case, or if there is doubt about the LNMP. Recent contraception history, especially hormonal, and recent history of breast-feeding. Calculate the expected date of delivery (EDD) using Naegle's Rule and estimate the current gestation.

Booking – When, where and how pregnancy and gestational age confirmed – e.g. by examination, pregnancy test, ultrasound scan. Date of quickening – foetal movements first or perceived.

Antenatal findings - Number of clinic visits, date of last visit, significant abnormal findings, and details of antenatal hospital admissions.

PAST REPRODUCTIVE (OBSTETRIC) HISTORY – (applies to a multigravida).
In chronological order give year of delivery, abortions or ectopic pregnancy, significant antenatal complications, delivery methods, birth weight or gestational age, and present condition of infant or cause death.

PAST MEDICAL AND SURGICAL HISTORY - Including gynaecological conditions not mentioned above like fibroids, cerclage, STIs, MVA, IUFD/Still birth
Also ask about DEATHS

DRUG HISTORY- Present medication and allergies – do not forget haematinics and ask about herbal or traditional medicines

FAMILY HISTORY- Multiple pregnancies, cardiovascular disease, diabetes, TB, sickle cell etc.

SOCIAL HISTORY- accommodation (number of rooms, number of people staying in house, source of water etc). family support at home, financial support, travel history (Malaria in pregnancy), Alcohol, smoking,

SUMMARY- Summarise significant positive findings before positive findings before proceeding to findings of examination. (Name, age, gravidity, parity, gestational age, main problems and risk factors – do not repeat the entire history again, RVD Status).