***Tishk International University  
 Faculty of Nursing***

**History Taking /physical examination lab**

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**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

**General information**

➢ Name

➢ Age

* Marital status

➢ Occupation

➢ Presenting complaint(present illness)

* Chief complains

**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 peroid)

➢ EDD “Expected date of delivery” (Naegele’s rule) // Add 7 days to the first day of LMP, subtract 3 months 0r (add 9month), one year //Example

LMP 27 /8/2014

EDD: 3/6/2015

* 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, irregular.

➢ Contraceptive history methods.

➢ 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 (hysterectomy, ovarian cyst)

Past medical and surgical history:

➢ Relevant medical problems

➢ any previuos 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 (abuse)

**Drug history / Allergies**

2- Obestetrics physical examination

* General examination
* Abdominal examination
* Lower limb examination
* Pelvic examination

**General exam**

➢ Weight

➢ Height

➢ BMI (weight (kg) /Height (m2 )

➢ Vital signs (blood pressure , pulse , respiratory rate , temperature )

➢ Breast examination (self examination in detecting breast masses.)

**Abdominal 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

Palpation

Uterine size → symphysis fundal height in cm = GA in wks

at 12-14 wks → just palpable

20-22 wks → at the umbilicus

**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.

➢ Ascultation

Listening for the fetal heart beat.

Lower limbs examination

* Swelling (edema)

➢ Varicosities

**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).

The contraindication to digital examination or pelvic examination

* 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).

Gynecology History

1- 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.

2- Vaginal discharge

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

3- 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

4- 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)