THE OBGYN HISTORY

FLAME LECTURE: 1

STELLER 8.20.23

LEARNING OBJECTIVES

- Demonstrate a comprehensive women's medical interview, including: menstrual, obstetrical, gynecologic, contraceptive, sexual, family/genetic, and social histories
- Communicate the results of the OB/GYN and general medical interview by well-organized written and oral reports
- Demonstrate the ability to obtain a sexual history, including sexual function and orientation
- Prerequisites:
  - NONE
- See also – for closely related topics
  - FLAME #20: The Well Woman Exam
  - FLAME #43: The OB Family History
  - FLAME #51: The Routine Return OB visit
  - FLAME #174: The UroGyn H&P

H&P DIFFERENCES

- In general, the only additions to the standard H&P include an Obstetrical History (POBH) & Gynecologic History (PGH)
- However, depending upon the type of visit, there are specific questions to be asked during the HPI
  - Well woman exam
  - Ambulatory New OB visit
  - Inpatient OB admission
  - Specialty service H&Ps (ex. Urogyn, GynOnc, REI)
  - Preconception Consultation

STANDARD H&P OUTLINE

- CC:
- HPI:
- PMH:
  - Hospitalizations:
  - ED Visits:
  - Health Maintenance:
  - Immunizations
  - Meds:
  - Allergies:
  - PSH:
- POBH:
- PGH:
- FH:
- SH:
- ROS:

PAST OB HISTORY

GRAVIDA / PARA

- Gravida: How many times one has been pregnant, ex. G4 = 4 pregs
- Para: The outcome of those pregnancies ("TPAL" system)
  - T: Term deliveries (37+ weeks)
  - P: Preterm deliveries (20-37 weeks)
  - A: Abortions - Includes ectopics, SABs, and TABs
    - How many weeks? Did patient have a D&C (or D&E)?
    - IUFDs after 20 weeks will fall in the T or P section, not A.
  - L: Number of Living children
- Note: If currently pregnant, the total Gs will be one more than the Ps
- Multiple gestations count as ONE pregnancy and ONE delivery (but likely multiple living children in the L part of the Gs and Ps)
- You can add details in parentheses after; i.e: G4P1021 (TAB1, SAB1)

PAST OB HISTORY

IMPORTANT ASPECTS FOR EACH DELIVERY

- Year of the delivery
- Route of delivery
  - Vaginal: NSVD (normal spontaneous vaginal delivery), VAVD (vacuum-assisted vaginal delivery), FAVD (forceps-assisted vaginal delivery)
    - If they had an assisted delivery, document WHY! (i.e., maternal exhaustion, NRFHRT [non-reassuring fetal heart rate tracing])
    - Were there any complications? (ex. scalp laceration, hematoma)
    - Did they have a laceration? If so, what degree (1st-4th)? They should know if they had a 3rd or 4th, because this affects delivery planning and future risk of flatal/fecal incontinence.
  - Cesarean: 1LTCS (primary low transverse cesarean section), RLTCS (repeat), classical cesarean section (vertical uterine incision)
    - Document why (ex. NRFHRT, arrest of dilation [how many cm], arrest of descent [what station]) and where (so we can get an op report)

PAST OB HISTORY

IMPORTANT ASPECTS FOR EACH DELIVERY

- Approximate gestational age:
  - Knowing if they had a preterm delivery (<37 weeks) is important for mgmt of their subsequent pregnancies (see FLAME #126)
  - If they had an early preterm cesarean section (<28w), it will be important to know why type of uterine incision they had
    - Ie., if they had a classical cesarean section (vertical hysterotomy), this holds implications for scheduling their next C/S prior to the onset of labor (typically @ 37w), and they cannot be offered a TOLAC (trial of labor after cesarean)
- Sex / Weight
- Epidural? Any complications? (i.e., have to redo it? Spinal headache?)
- Antepartum, intrapartum, or postpartum complications? (i.e., preE, postpartum hemorrhage?)

PAST GYN HISTORY

- Age at menarche
- Characteristics of menses
  - General: regular or irregular
  - Frequency: how often, ex. q28-30 days
  - Duration: days of flow, ex. 4-5 days of flow
  - Volume: if heavy, how many pads per day
  - Ex. “Menses: reg, q28d, 4-5 days of moderate flow”
- Age at menopause
- Sexual history (see future slide)

PAST GYN HISTORY

- History of STIs (sexually transmitted infections)
  - If positive, document if they were treated, their partner was treated, and that a test of cure (TOC) was performed
- History of abnormal pap
  - If abnormal, ask if they know the path (ASCUS, ASC-H, LSIL, HSIL); most likely they will not know, but we can get an idea by their history
    - Thus, ask if they had colposcopy and/or biopsies; if yes, do they remember the path (benign, CIN 1, CIN 2, CIN 3)?
    - Then ask, "so what happened next?" Did they need a procedure like a LEEP or a CKC (cold knife cone)? Did they just need a pap in 6 or 12 months? Did they need colpo again, or have they all been normal?
    - When was your last pap (month/year)?

PAST GYN HISTORY

SEXUAL HISTORY

- Sexual Practices
  - Sexual orientation ("men, women or both?")
  - Vaginal, anal, oral sex? Condoms?
  - # of partners in last 1-2 years?
  - Does the patient feel safe in her relationship?
  - Feel forced to exchange sex for drugs or money?
- Sexual Dysfunction / Dissatisfaction
  - The problem as the patient sees it
  - How long has the problem been present?
  - Is the problem related to the time, place, or partner?
  - Is there a loss of sex drive or dislike of sexual contact?
  - Are there problems in the relationship?
  - What are the stress factors as seen by the patient and by the partner?
  - Is there other anxiety, guilt, or anger not expressed?
  - Are there physical problems such as pain felt by either partner?
- For addressing high risk sexual behaviors (see FLAME #2)

POBH / PGH EXAMPLE

- POBH: G3P1112
  - G1 – 2013 – 1st tri SAB – needed D&C
  - G2 – 2014 – 1LTCS at 39w 2/2 NRFHRT – M – 9lb – uncomplicated
  - G3 – 2015 – RLTCS at 34 weeks 2/2 preterm labor in setting of breech – F – 5 lb 2 oz; c/b uterine atony; req 1U PRBCs
- PGH:
  - Menarche: 12 y/o
  - Menses: reg, q28d, 4-5 days of light flow
  - Hx of CT s/p treatment in 2014; TOC neg; partner treated
  - Hx of abnl pap in 2014; s/p colpo w/ benign biopsies; normal paps since, last pap 5/2023
  - Sexually active with monogamous partner; no dyspareunia or other concern

WELL WOMAN EXAM HPI/ROS

- Gynecologic aspects to be included:
  - Any plans to become pregnant in the next 12 months?
    - If not, what is she using for contraception? If so, she will need preconception counseling.
  - First day of her last menstrual period (LMP)
  - Gynecologic "triad" = age at menarche / length of cycle (days) / duration of menses (days)
    - Severe pain, heavy bleeding or clots? Intermenstrual bleeding?
  - She denies menopausal symptoms of hot flashes, vaginal dryness, or mood changes.
  - She denies having any new sexual partners, and denies any vaginal discharge, pelvic pain, itching, burning, or dyspareunia (STI risk factor screening)
  - She denies any irregular abdominal pressures, fullness, bloating, persistent indigestion, or new masses in her abdomen (ovarian cancer symptoms)
  - She denies any breast pain, discharge, or new masses palpated
  - She denies any urinary/fecal urgency, incontinence with laughing/coughing, or bulge symptoms (see FLAME #174).

OBSTETRICAL HPI

- The “two-liner”: gives the personal characteristics of the patient and her pregnancy, and should feature:
  - Age
  - Gender: don’t need to report if female, however, would report if trans
  - Gravida / Para
  - Gestational age w/ confirmation of dating (see FLAME #50)
  - Why they are presenting (ex. ROB [routine OB visit], NOB [new OB visit], or presenting with a specific complaint)
  - Complications of the pregnancy
- Ex. 26 yo G3P2002 at 26 4/7 weeks by LMP c/w 1st tri sono who presents to OB triage with new onset vaginal bleeding. Her pregnancy is complicated by A1DM and central placenta previa.

OBSTETRICAL HPI/ROS: 1st Way

- Core 4: Any contractions, leakage of fluid, vaginal bleeding, or decreased fetal movement?
- PreE 4: Any headaches, visual changes, RUQ/epigastric pain, or new rapid-onset swelling?
- ROS: Fever/Chills, CP/SOB, N/V, D/C, dysuria, vaginal discharge, or calf tenderness?

OBSTETRICAL HPI/ROS: 2nd Way

- A – Amniotic fluid? ("leakage of fluid" or LOF)
- B – Bleeding?
- C – Contractions?
  - May manifest as intermittent low back pain or pelvic pressure, or abdominal hardening or tightening
- D – Dysuria?
- E – pre-Eclampsia symptoms?
  - HA, visual change, RUQ/epigastric pain or non-dependent edema?
- F – Fetal movement?
  - Concerning if decreased or absent, then ask for severity and duration

THE OB PROBLEM LIST

- The problem list is a unique feature of an Obstetrical H&P that serves as a comprehensive list of pregnancy complications and other features of the patient's history or exam that are risk factors for future complications
  - Found just under HPI in inpatient H&P, maintained longitudinally somewhere in outpatient chart (at FHC-SA it's usually in the resident's assessment and plan each visit)
- Problem number 1 is always "IUP/Dates" and describes how the pregnancy is dated
  - In an inpatient H&P, problem #2 is the reason for admission
  - Otherwise, problems proceed generally in order of importance/severity
- The purpose is to quickly give the providers caring for a patient all of the information they need to care for a patient, especially in emergency situations
- They also serve as a highly effective tool for signing out or handing off patients
- An example is on the next slide

THE OB PROBLEM LIST

PROBLEM LIST

Dating: by LMP c/w 12wk sono

- LMP: 8/18/16 → EDD 5/25/17
- US #1: 11/11/16 – 12 1/7 WBD (weeks by dates), 12 1/7 WBS (weeks by sono) thus confirming EDD

Hx of C/S x 1 for AOD at 6cm; desires RLTCS, declines TOLAC

A2DM: currently on glyburide 2.5mg daily; well controlled

Class 3 Obesity: BMI 46; 19lb weight gain this preg

GBS unknown

OTHER CONSIDERATIONS

- Family History
  - Ask about cancers found in gyn-related congenital cancer syndromes (see FLAME #3 for more detail)
    - BRCA: breast, ovarian, pancreatic, colon, gastric, melanoma, leukemia/lymphoma
    - HNPCC: colon, endometrial, ovarian, stomach, small intestine, hepatobiliary tract, urinary tract, brain, skin
    - Cowden syndrome: hamartomatous cancers of the breast, uterus, thyroid, and kidney
  - Ask about any congenital or genetic disorders or anatomical anomalies that run in the family (see FLAME #43 for more detail)
- Social History
  - In OB patients, it is important to know if the FOB (father of the baby) is involved and supportive; if not, who in the family is

BRIEF GYN H&P OUTLINE

CC: WWE

HPI: 42 yo G0 who is presenting for her annual WWE.

- Her LMP was 11/2/16, and she denies any irregular bleeding, intermenstrual bleeding, or menorrhagia.
- She denies any hot flashes, vaginal dryness, or mood changes
- She denies any new sexual partners, vaginal discharge, pelvic pain, itching, burning, or dyspareunia
- For contraception the patient is using the NuvaRing; has been using for last 9 months
- She denies any irregular abdominal pressures, fullness, bloating, persistent indigestion, or new masses in her abdomen
- She denies any breast pain, discharge, bleeding, or new masses palpated on self-breast exams.

ROS: Denies any F/Ch/CP/SOB/N/V, diarrhea, constipation, or dysuria.

POBH: G0

PGH:

- Menarche: 12 y/o
- Menses: reg, q28d, 4-5 days of light flow
- Denies any hx of STIs or abnormal paps
- Sexual active with monogamous partner

PMH: HTN

PSH: LSC cholecystectomy in 2012

MEDS: HCTZ 25mg daily

ALLERGIES: none

FH: no gyn/breast/colon/panc/skin cancers; no congenital anomalies

SH: no T/E/D; works as an accountant

BRIEF OB H&P OUTLINE

CC: Labor

HPI: 28 yo G2P1001 at 38 2/7 weeks by LMP c/w 12wk sono who presents with painful contractions q5m. Her pregnancy is uncomplicated.

She denies LOF, VB, or DFM. She denies headache, visual changes, RUQ pain, or new-onset swelling.

ROS: She further denies F/Ch/CP/SOB/N/V, diarrhea, constipation, vaginal discharge, dysuria, calf tenderness, or new itching/rash.

PROBLEM LIST

Dating: by LMP c/w 12wk sono

- LMP: 8/18/16 → EDD 5/25/17
- US #1: 11/11/16 – 12 1/7 WBD, 12 1/7 WBS thus confirming EDD
- US #2: 1/15/17 – S=D, NL anatomy, post placenta, no previa

GBS negative

POBH:

- G1: 2013 – NSVD – 39w – M – 7lb 8 oz – uncomplicated
- G2: current

PGH:

- Menarche: 12 y/o, Menses: reg, q28d, 4-5 days of light flow
- Denies any hx of STIs or abnormal paps

PMH: none

PSH: LSC cholecystectomy in 2012

MEDS: PNV, Iron

ALLERGIES: none

FH: no gyn/breast/colon/panc/skin cancers; no congenital anomalies

SH: no T/E/D; FOB involved and supportive

ASSESSMENT/PLAN

- The first problem in the A/P is Supervision of Normal pregnancy OR Supervision of High-Risk Pregnancy

 # Supervision of High-Risk Pregnancy:

- *Dating*: by LMP c/w 12 wk sono --> EDD 1/1/2024
- *PNL*: O+ / Ab neg / RI / HBSAG neg / HIV neg / RPR neg / GC/CT neg / Pap WNL / 1 hr: 120 / A1c: 5.4 / TSH 1.5 / 25 OHD: 42
- *Genetics*: NT WNL, cfDNA: reassuring, 46 XX; declined carrier screening
- *D&A*: S=D, normal anatomy, placenta anterior
- *Vaccines*: s/p flu, TDAP > 27 weeks
- *Precautions*: PTL, preE, FKC precautions given
- *PPBCM*: desires post-placental Mirena IUD, auth placed
- *Feeding*: desires to BF x 12 months, breast pump ordered
- *Dispo*: ROB appt in 4 weeks