History taking Obstetrical

A

Name: **d/o, w/o:** **Age:**
Sex: **Weight:** **Height:**
Mode of admission: _________ **Date of admission:** _________________

- Gravidity ______________
- Parity ______________
- Abortion ______________
- LMP ______________
- EDD ______________

B

1. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
   If married than,
   - married for:______________
   - Cousin marriage Yes ☐ No ☐
2. Occupation:____
3. Preferred phone number:______________________
4. Partner:____☐None
5. Age of partner: _________________________________
6. Occupation of partner: ________________________
7. Referring Physician: ____________________________

C **Presenting complains:**

____

____

____

D **MENSTRUAL HISTORY** (complete even if post-menopausal or no longer having periods)

1) Age at first period:_____years. (sb sy pehli mahwari kb hoi thi?)
2) Duration of bleeding:___days (mahwari kitny din k liyay ati hai amuman?)
3) Length of each cycle: (kitny dinon baad kitny din kkee mahwari hoti hai?)
4) If your menstrual periods are regular; periods start every:_days (har baar eitny dino kee mahwari hoti hai?)
5) If your menstrual periods are irregular; periods start every:______to____days
6) Does bleeding or spotting occur between periods? Yes☐ No☐
7) Does bleeding or spotting occur after intercourse? Yes☐ No☐
8) First day of last menstrual period ______________________
   Day Month Year
9) Is pain associated with periods? Yes☐ No☐ Occasionally☐
10) If yes to point 8, is it: before menses?☐ during menses? ☐ both? ☐

E History of Present Illness

- ⇨ **L**ocation and radiation: ____________________________
- ⇨ **C**haracter: ___________________________
- ⇨ **A**lleviating and aggravating factors: _______________________
- ⇨ **T**iming, constant, happened in past: _________________________
- ⇨ **E**nvironment or setting: ___________________________
- ⇨ **S**everity or disability (0 - 10 scale)
- ⇨ **O**ther associated symptoms: ____

- **1st trimester:**

1. Pregnancy number:
2. Planned/unplanned: (Kia ap ne is hamal ka irada kia tha?)
3. Wanted/unwanted (Kia ap chahti thin keh ye hamal taharay?)
4. Confirmation of pregnancy: (ap ko kaisay pata chala k apka hamal tehar chukka hai?)

   ☐ **UPT** (Urine Pregnancy Test) ☐ Scan
5. Conceived method: (Kia ap nay is hamal k lie koi ilaj karwaya tha?)

   ☐ Spontaneous ☐ Induced

6. Folic acid:	Yes ☐	No ☐
7. Nausea	Yes ☐	No ☐
8. Vomiting	Yes ☐	No ☐
9. UTI	Yes ☐	No ☐
10. Vaginal infection	Yes ☐	No ☐
11. Vaginal discharge (khoon ka ikhraj toh nahi hota)	Yes ☐	No ☐
12. Vaginal bleeding (Pani toh nahi prta)	Yes ☐	No ☐

History taking Obstetrical

- **2nd trimester:**
  1) Booked or not? (apka card bna howa hai?) Yes ☐ No ☐
  2) Fetal movement Yes ☐ No ☐
  3) Anomalies scan (18-22 weeks) Yes ☐ No ☐
  4) Iron tablets Yes ☐ No ☐
  5) Calcium tablets Yes ☐ No ☐
  6) Gestational Diabetes Yes ☐ No ☐
  7) Gestational Hypertension Yes ☐ No ☐
  8) Anemia Yes ☐ No ☐
  9) UTI Yes ☐ No ☐
  10) Vaginal infection Yes ☐ No ☐
  11) Vaginal discharge Yes ☐ No ☐
  12) Vaginal bleeding Yes ☐ No ☐
  13) Polydipsia Yes ☐ No ☐
  14) Polyuria Yes ☐ No ☐
  15) Polyphagia Yes ☐ No ☐

- **3rd trimester:**
  1) Fetal movement Yes ☐ No ☐
  2) **USG** (Ultra sound in pregnancy) Yes ☐ No ☐
  3) **CTG** (Cardiotocography) Yes ☐ No ☐
  4) **BSL** (Blood sugar level) Yes ☐ No ☐
  5) **FKC** (Fetal kidney circumference) Yes ☐ No ☐
     Yes ☐ No ☐
  6) Gestational Diabetes Yes ☐ No ☐
  7) Gestational Hypertension Yes ☐ No ☐
  8) Anemia Yes ☐ No ☐
  9) UTI Yes ☐ No ☐
  10) Vaginal infection Yes ☐ No ☐
  11) Vaginal discharge Yes ☐ No ☐
  12) Vaginal bleeding Yes ☐ No ☐
  13) Polydipsia Yes ☐ No ☐
  14) Polyuria Yes ☐ No ☐
  15) Polyphagia Yes ☐ No ☐

F PREGNANCY HISTORY (All pregnancies) Have never been pregnant ☐

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

CHILD									
Year	Place of delivery or Abortion	Duration Preg.	Type of Delivery	Complications			Sex	Birth Weight	Present Health
				Ante-natal	Labour	Post-delivery			

G BIRTH CONTROL HISTORY

(ap nay kabhi ehtiyati tadaabaeer istemaal kee hein?)

1. Do you use any birth control method: ☐ Yes ☐ No

If yes than,

- What birth control method(s) do you use? ____________________
- Duration: ____________________

H SEXUAL HISTORY

1. Do you have a sexual partner? Yes ☐ No ☐
2. Are there concerns about your sexual activity which you may want to discuss with your doctor? Yes ☐ No ☐

I PAP SMEAR/MAMMOGRAM HISTORY ☐ None

(sheeshay wala test hua hai apka kabhi?)

1. ☐ Date of last pap smear: ____________________
2. ☐ Have you had abnormal pap smears? Yes ☐ No ☐
3. ☐ Have you had treatment for abnormal smears?

No ☐ Yes ☐ { Loop excision / Cone biopsy / Laser }

4. Date of last mammogram: __________ (month) __________ (year)

5. Have you had an abnormal mammogram?

Yes ☐ No ☐

J PAST OBSTETRICAL/GYNECOLOGICAL SURGERIES

Check any that apply: or ☐ None

SURGERY	YEAR	SURGERY	YEAR
☐ D & C		☐ ovarian surgery	
☐ Hysteroscopy		☐ L cyst(s) removed ovarian	
☐ Infertility surgery		☐ R cyst(s) removed ovarian	
☐ tuboplasty		☐ L ovary removed	
☐ tubal ligation		☐ R ovary removed	
☐ laparoscopy		☐ vaginal or bladder repair	
☐ hysterectomy (vaginal)		☐ cesarean section	
☐ hysterectomy (abdominal)		☐ other (specify) ____________________	
☐ myomectomy			

*D & C = Dilation and curettage

K PAST SURGICAL HISTORY (Not OB/GYN)

List all surgeries and their year or ☐ None

Surgeries	Year

OTHER PAST GYNECOLOGICAL HISTORY

1. Check any that apply: or ☐ None
   - ☐ Venereal warts
   - ☐ Herpes – genital
   - ☐ Syphilis
   - ☐ Pelvic inflammatory disease
   - ☐ Endometriosis
   - ☐ Chlamydia
   - ☐ Gonorrhea
   - ☐ Vaginal infections
   - ☐ Other ______________________

L PAST MEDICAL HISTORY Check any that apply: or ☐ None

- ☐ Arthritis
- ☐ Diabetes
- ☐ Diet controlled
- ☐ Pill controlled
- ☐ Insulin controlled
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Kidney Disease
- ☐ Gallstones
- ☐ Liver Disease (including hepatitis)
- ☐ Epilepsy
- ☐ Blood Transfusions
- ☐ Thyroid disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ HIV+
- ☐ Eating Disorder
- ☐ Other: ________

M CURRENT MEDICATIONS (Include dose (amount) per day)

Medication	Dose	Frequency

N DO YOU CURRENTLY?:

1. Smoke No ☐ Yes ☐ ____packs/day
2. Use alcohol No ☐ Yes ☐ _wine (glasses/day); beer (bottles/day); hard liquid (oz./day)
3. Use illicit drugs No ☐ Yes ☐ ___________type ______________amount
4. Exercise: Type:_________________How often ______________________

O DRUG ALLERGIES

8. No ☐ Yes ☐

List:

____

____

____

P FAMILY HISTORY

☐ Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Other

☐ Ovarian Cancer ☐ Endometrial Cancer ☐ Colon Cancer ________________

____

If "yes" to any, please list affected relatives

____________________________________ ____________________________________

____________________________________ ____________________________________

☐ None of the above.

Q OTHER SYMPTOMS

Have you had recent?:

☐ weight loss	☐ hair growth	☐ none of the above
☐ weight gain	☐ hair loss	☐ Other: ________________
☐ change in energy	☐ change in urinary function	____________________
☐ change in exercise tolerance	☐ hot flushes/flashing	____________________
	☐ breast discharge	

R

Note: Fill out Section "P" only if you are pregnant or planning to be pregnant in the near future.

Have you or the baby's father or anyone in your families ever had any of the following:

Down Syndrome (Mongolism)? If yes, who?____

Other Chromosomal abnormality? If yes, specify ___________________________________

Neural tube defect (spina bifida, anencephaly)? If yes, who? ________________________

☐ Hemophilia or other coagulation abnormality? If yes, who? _________________________

☐ Muscular Dystrophy? If yes, who? ____

☐ Cystic Fibrosis? If yes, who? ____

☐ Have either of you been screened for Tay-Sachs disease?

☐ Father Result______________________________________

☐ Mother Result ______________________________________

☐ Have either of you been screened for Sickle cell trait?

☐ Father Result____________________________________

☐ Mother Result ____________________________________

☐ Have either of you been tested for B-thalessemia?

☐ Father Result____________________________________

☐ Mother Result ____________________________________

☐ Have either of you been tested for A-thalessemia?

☐ Father Result____________________________________

☐ Mother Result ____________________________________

____ ______________ __________

PATIENT SIGNATURE DATE TIME

____ ______________ __________

PHYSICIAN SIGNATURE DATE TIME