Obstetric History Taking

INTRODUCTION		
1	Introduces themselves	
2	Confirms patient details	
3	Establishes presenting complaint using open questioning	
4	Confirms gestation, gravidity and parity of the patient.	
HISTORY OF PRESENTING COMPLAINT		
5	Onset & duration	
6	Severity	
7	Course	
8	Intermittent or continuous	
9	Exacerbating and relieving factors	
10	Associated features / Previous episodes	
OBSTETRIC SYMPTOMS		
11	Nausea and vomiting	
12	Reduced fetal movements	
13	Vaginal bleeding	
14	Abdominal pain	
15	Vaginal loss (abnormal vaginal discharge or SROM)	
16	Headaches / Visual disturbance / Epigastric pain (pre-eclampsia symptoms)	
17	Pruritis	
CURRENT PREGNANCY		
18	Current gestation	
19	Scan results	
20	Screening results	
21	Singleton or multiple gestation	
22	Folic acid use	
23	Planned mode of delivery	
24	Medical illness during pregnancy	
25	Immunisation history	
26	Mental health history	

PREVIOUS OBSTETRIC HISTORY		
27	Gravidity / Parity	
28	Term pregnancies (birth weight, mode of delivery, complications, stillbirth)	
29	Other pregnancies (miscarriage, terminations, ectopic pregnancy)	
GYNAECOLOGICAL HISTORY		
30	Cervical screening	
31	Gynaecological disease	
PAST MEDICAL HISTORY		
32	Medical history (diabetes, hypothyroidism, epilepsy, VTE, BBV, genetic disease)	
PAST SURGICAL HISTORY		
33	Previous surgical procedures (e.g. caesarian sections)	
DRUG HISTORY		
34	Regular medications	
35	Contraception (prior to pregnancy)	
36	Over the counter medication	
37	ALLERGIES	
FAMILY HISTORY		
38	Inherited genetic conditions, diabetes, pre-eclampsia	
SOCIAL HISTORY		
39	Smoking history / Alcohol intake	
40	Recreational drug use	
41	Diet and weight	
42	Home situation / Level of functional independence / Occupation	
43	Domestic abuse	
SYSTEMIC ENQUIRY		
44	Screens for symptoms in other body systems	
CLOSING CONSULTATION		
45	Thanks patient	
46	Summarises salient points of the history	
KEY COMMUNICATION SKILLS		
47	Active listening	
48	Summarising	
49	Signposting	