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Some History-taking Tips in Gynaecology

Despite the advances in pathology testing and imaging, a diagnosis is more often best made by listening to the patient and asking a few key questions. However, in my experience, these questions need to be phrased in a particular way to elicit the revealing clues. What follows is my 35-year experience in gynaecological history-taking. The reasons or significance in each question I have indicated by the text in italics.

For Menstrual Bleeding

- How often do your periods come? When you say "regularly" do you mean monthly? Does that mean about once in each calendar month or is that exactly every 28 days? Does that mean your period starts on the same day of the week every month?

Very few women these days keep a menstrual calendar. If they do then ask to see it. It can be a most rewarding experience. Make sure that you tell them so!

- When you say "irregular" does that mean that they are coming more or less often than once in each four weeks? How much earlier? How much later?

Many women don't think of cycles from the beginning of one period to the beginning of the next. They usually think in terms of when they are expecting the next period. First establish how often they expect their period and then ascertain how much "early" or "late" they are coming.

- Is each episode a "full period" or can you distinguish between normal periods and other episodes of bleeding? If so, when do you get the periods and when do you get the other bleeding?

This question is often vital in deciding whether a patient is having intermenstrual bleeding or completely acyclical bleeding. If they are supposed to be taking a pill ask them exactly what is happening during the week of placebo medication.

- Is it related to intercourse or pill taking? Does the "breakthrough" or "spotting" occur early, late or in the middle of a cycle? Are you taking your hormone or contraceptive pills at the same time each day? What happens when you are late or miss a pill or pills?

These questions provide clues to the common causes for intermenstrual bleeding.

- When you period starts, does it start with a full flow or does it "muck around for a bit first"? If so, how long?

Premenstrual staining for more than 24 hours correlates very strongly with pelvic endometriosis for patients who are cycling spontaneously ie without pills or hormones.

- How many heavy days and how many light days do you have during a period? What do you mean by "heavy"? What do you mean by "flooding"? How many pads are tampons are you using on that day? Are you changing because they are soaked or for other reasons? What do you use at night? Do you get up at night to change? Have you had any "accidents"? Does the amount of bleeding you experience on those heavy days affect what you would like to be doing that day? If so, exactly how or what?

These questions may help to determine whether the patient's menstrual loss is really excessive or only perceived as excessive.

- Have you seen any clots? If so what are they like? Just stringy small ones? Pinhead size or larger? How big? Ten cent size, twenty cent size, fifty cent size? Show me with your fingers or hand. Golf ball size? Orange size or larger?

Normal menstrual fluid is only 50% blood and 50% is endometrial cells and fluid. The latter usually contains sufficient fibrinolysins to lyse any blood clots whereas blood loss that is excessive will often appear as "clots". However, small clots can be "normal" and may only occur during some menstrual periods but not others. It is sensible to ALWAYS do a Haemoglobin and Ferritin estimation on a patient who is consulting you about heavy periods. Some women can be significantly iron deficient even without much complaint on their part. Others who are complaining bitterly about the number of pads they are using or the size of their clots have normal HB and Ferritin. You then have to ask yourself what is their real problem.

For Pelvic Pain

- Do you get pain with your periods? Have you always had these types of pains with your periods? If not, when did they start and is the pattern changing? Which is the worst day? What do you use for the pain? How many tablets exactly? Does the pain you experience on those days affect what you would like to be doing that day? If so, exactly how or what?

Primary dysmenorrhoea i.e. that which is not associated with treatable pelvic pathology, classically begins when ovulatory cycles establish and is usually worse on the day or days before the onset of menstrual flow or the first few days of menstruation. Secondary dysmenorrhoea, which is most commonly due to endometriosis (and sometimes PID) classically gets worse as the period progresses and may linger on for some days after menstruation has ceased. Both types of dysmenorrhoea commonly coexist and can respond to the same measures ie NSAIDs and or a combined oral contraceptive.

- When you get your periods do you have any problems with you bowels? Does it hurt to have a bowel action?

Loose bowel actions during menstruation are quite common and presumably reflect the presence of pelvic prostaglandins. Pain with defaecation during menstruation correlates strongly with endometriosis of the rectovaginal septum.

- Where exactly do you get the pain? What is it like? When you say "sharp" do you mean severe or sudden or like a knife? Does it occur suddenly or begin slowly? How long does it last? Seconds, minutes, hours or days? How does it go away? Is it like a period pain or a labour pain or is it a different type of pain? What do you use for the pain? How many tablets exactly? Does the pain you experience on those days affect what you would like to be doing that day? If so, exactly how or what? Has it ever woken you at night? Or stopped you sleeping? When do you get the pain? When you say "mid cycle" do you mean exactly two weeks after the beginning of one period and the beginning of the next or just some time between periods. Is the pain ever set off by intercourse? By other physical activities? By bladder or bowel action? Any relationship to eating or meals? Have you noticed anything else when you get the pain? For example vaginal discharge or urine or bowel symptoms?

Remember that the pelvis contains bowel, an appendix sometimes, bladder, lymph nodes, blood vessels, nerves and muscles and even two joints (the sacroiliac joints and pubis symphysis) all or any of which can be causing pain as well as the female reproductive organs!

For Infertility

- How long have you been in your current relationship? What methods of contraception or avoiding pregnancy have you used and when did you stop using it?

Many patients are referred to me after 12 months or even two years of "trying to fall pregnant" but, in fact, have not been using contraception or using fairly haphazard contraception for years. The most important indicator of the need for assisted conception technology is the number of cycles in which pregnancy was possible but did not occur. I am amazed at the number of patients who, when asked about contraception, think only of "The Pill" hence the need to ask about "avoiding pregnancy" as well as contraception.

- Have you ever been pregnant or tried in any previous relationship?

This question is best explored in the absence of the male partner. It is sometimes very important not only as an indicator of a male problem, but also because of the guilt and anxiety about previous termination of pregnancy and or its sequelae e.g. tubal disease. The male corollary to this question is sometimes just as rewarding.

- Have you ever fathered a pregnancy before or tried in any other relationship?

The answer, even in the presence of the female partner, is often: "Not that I am aware of" – *nod and wink. Male promiscuity is accepted as the norm whereas there is sometimes still sensitivity about previous female activity or pregnancies. All answers to these questions tell us something about the risk of sexually transmitted disease whereas this can be absolutely excluded if neither partner has had any sexual and genital experience with any other partner.*

If either partner admits to trying in another relationship or even inadequate or no contraception in another relationship I usually follow up with the question:

- And has that person subsequently proven fertile (become pregnant or fathered a pregnancy) in

their subsequent relationship(s)?

Rapid fertility with a change of partners is a fairly certain indicator of a problem in the partner abandoned. This can be quite helpful in the identification of what is called in the industry of making babies "a male factor problem".

- Have you ever been treated for inflammation of the pelvis or tubes? Chlamydia? A sexually transmitted infection? Genital Herpes? Wart virus? An abnormal Pap smear with pre cancer changes or CIN? Do you know if any of your partners have been treated or suffered from any of these conditions? Have you ever used an intra uterine contraceptive device?

  Each of these is an indicator for possible tubal problems. It is also worth exploring the circumstances of each or any pregnancy outcome particularly a history of fever, PV discharge or most commonly, bleeding associated with retained products of conception.

- How often is intercourse occurring? Do either of you have any problems with that?

This is the better way of asking about frequency of intercourse and takes the pressure off a bit. For couples that have been in their relationship for years, have busy professional lives or travelling schedules it can be a major factor. It is also the reason I still use a basal body temperature chart with a prospective evaluation of coital frequency. It is often much less than the couple will admit to at their first visit.

- When you say your periods are "irregular" does that mean that they are coming more or less often than once in each four weeks? How much earlier? How much later?

Most women who are menstruating at 24 – 34 intervals are, in fact, ovulating no matter how "irregular" they think this is. Few women have regular 28-day cycles every time for year after year. Such periods occur only with "The Pill". For spontaneous cycling women at least one cycle in 12 can be anovulatory or with a short luteal phase, so this is probably "normal". Fertility nurses refer to these as "whoopy cycles". It's as good a description as any.

For Prolapse and Urinary Problems

- Is there something coming down? Does it come right out? Have you ever felt anything when standing in the shower?

This last is the most frequent time that a woman discovers a "balloon" of prolapse. It may disappear when she lies down for examination but will usually appear if you ask her to "strain down".

- Can you strain to pass a bowel action? If not what happens?

Women with a rectocele are unable to strain during defaecation because it simply results in the posterior vaginal wall prolapsing. Some use their fingers to reduce the prolapse so that they can initiate defaecation.

- Can you get your urine stream started okay? Do you always empty your bladder completely?

These are the equivalent problems relating to cystocele and, together with recurrent cystitis, are more an indication of this problem than is urinary frequency or incontinence.

- Do you ever wet? Under what circumstances?

These are better questions than "Have you ever lost control of your water (or bladder) when you cough or sneeze"? Most women, at some stage of their lives, have experienced "stress incontinence" so this is normal except when it interferes with their lives or activities. Ditto for urge incontinence for which the prompt is:

- Do you have to get to the toilet in a hurry? Do you often wet before you make it?

- Do you get up at night to pass urine? If so, how often? Always or only sometimes? Is it because you have to get up or are you awake anyway? How long can you hang on during the day if you really have to or you are too busy to go?

A woman who gets up three times at night but can go for hours during the day has a sleep problem, not a bladder problem by and large. Unfortunately, bladder dysfunction is a more common problem than the "plumbing problems" associated with prolapse and for which there are effective surgical solutions.

Sexually Transmitted Disease (including Pregnancy)

- How long have you been in your current relationship?

Sexually transmitted disease (STD) usually occurs quite early in a new relationship. The corollary is also true. PID is rare in a stable monogamous relationship in the absence of instrumentation of the genital tract or pregnancy. This is not STD. Of course STDs can occur in a longstanding relationship if the other partner is "having an affair". In that situation it is often tactful to enquire about opportunity e.g. does the other partner travel away from home or spend nights away etc. Most patients will know what you are getting to and, even if they have not thought about it before, will usually "spill the beans".

- This may seem like an impertinent question, but how many sexual relationships have you had in the past 6 months? 12 months? Five years etc.

It is wise to also enquire about the age, life and lifestyle of the current partner and your partner's knowledge of his sexual promiscuity. Often the most difficult question to ask is the obvious one:

- Are you currently in a sexual relationship? Would you answer me the same way for this and the next question if your mother wasn't here! When did you last have intercourse?

It is said that, if your patient says no to the first question but then consults her watch instead of your desk calendar after the last question, then you know that you have a problem! It is never wise to assume that a woman on the Pill is sexually active. Or that "sexually active" means heterosexual genital intercourse. The truly difficult ones like to see you floundering away with these issues. So, if you think your patient knows what you are on about but is not being helpful, then turn it around and

tell them that you can't help unless they are quite specific in what they mean.

- Are all pregnancies to the same father?

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