The Ob-Gyn Clerkship: Your Guide to Success

Tools for the Clerkship, contained in this document:

1. Sample obstetrics admission note
2. Sample delivery note
3. Sample operative note
4. Sample postpartum note
    a. Vaginal delivery
    b. Cesarean section orders/note
5. Sample gynecologic history & physical (H&P)
6. Admission orders
7. Commonly-used abbreviations
8. Spanish lesson

1. Sample Admission to Labor and Delivery Note

Date & time
Identification (includes age, gravidity, parity, estimated gestational age, and reason for admission):
26yo G3P1A1 @ 38W5D EGA presents with painful contractions since noon. Pt reports good fetal movement, and denies rupture of membranes or vaginal bleeding.
LMP:
Estimated date of confinement (EDC):
Chief complaint:
History of present illness (includes Prenatal Care (PNC): Labs, including HIV, GBS, GDM/HTN, # PNC visits, wt gain, s=d, etc.
Past history:

- **Obstetrics:**
  - List each pregnancy (NSVD, wt 4000 grams, complicated by gestational diabetes and shoulder dystocia)
- **Gynecology**:
- **PMH and PSH:**

Medications: PNV, FeSO4
Allergies: No Known Drug Allergies (NKDA)
Social history: Ask about Tobacco/EtOH/Drugs
Physical exam (focused):

- General and Vital signs
- Lungs
- CV – (Many pregnant women have a grade 1-2/6 systolic ejection murmur
- Abd – Gravid, fundus non-tender (NT), fundal height (FH) 38cm, Leopold maneuvers:
  - Fetus is vertex (VTX), estimated fetal weight (EFW) 3300 gm
- Sterile speculum examination if indicated to rule out spontaneous rupture of membranes (SROM)
- Sterile vaginal exam (SVE) = 4cm/80%/VTX/ –1 as per Dr. Smith/time
- Ext – No Cyanosis, clubbing or edema (C/C/E), NT

Pertinent Labs:
Ultrasound: Date: 10 wks by crown-rump length (CRL)
Date: 20 wks, no anomalies
Assessment: 26yo G3P1 at term, in labor fetal heart rate tracing (FHRT) reassuring

- Intrauterine pregnancy (IUP) at 39 weeks gestation
- FHRT – Baseline 140's, accelerations present, no decelerations
- Contractions – q 4-5 min
- Any pertinent past medical or surgical history

Plan: Admit to L&D

- NPO except ice chips
- IV – D5LR at 125 cc/hr
- Continuous electronic fetal monitoring
- CBC, T&S, RPR
- Anticipate NSVD

2. Sample Delivery Note

Date and time:
Summary: NSVD of a live male, 3000 gm and Apgars 9/9. Delivered LOA, no nuchal cord, light meconium. Nose and mouth bulb suctioned at perineum; body delivered without difficulty. Cord clamped and cut. Baby handed to nurse. Placenta delivered spontaneously, intact. Fundus firm, minimal bleeding. Placenta appears intact with 3 vessel cord. Perineum and vagina inspected – small 2nd degree perineal laceration repaired under local anesthesia with 2-0 and 3-0 chromic suture in the usual fashion. EBL 350cc. Hemostasis. Pt tolerated procedure well, recovering in LDR. Infant to WBN.

3. Sample Operation Note

Date and Time:
Pre-op Diagnosis: Symptomatic uterine fibroids or Pregnancy at term, failure to progress`
Postop Diagnosis: Same
Procedure: TAH/BSO or Cesarean Section
Surgeon (Attending):
Residents:
Anesthesia: GET (general endotracheal, others include spinal, LMA, IV sedation)
Complications: None
EBL: 300 cc
Urine Output: 200 cc, clear at the end of procedure
Fluids: 2,500 cc crystalloid (include blood or blood products here)
Findings: Exam under anesthesia (EUA) and operative
Spécimen: Cervix/uterus
Drains: If placed
Disposition: Recovery room, Surgical ICU, etc

4a. Sample Postpartum Notes (Soap format)

Date and Time:
Subjective: Ask every patient about:

- Breastfeeding – are they breastfeeding/planning to? How is it going? Baby able to latch on?
- Contraceptive plan with relevant sexual history
- Lochia (vaginal bleeding) – Clots? How many pads?
- Pain – cramps/perineal pain/leg pain? Relief with medication? Do they need more pain meds?

Objective:

- Vital signs and note tachycardia, elevated or low BP, maximum and current temperature
- Focused physical exam including
    - Heart
    - Lungs
    - Breasts: engorged? Nipples – skin intact?
    - Abd: Soft? Location of the uterine fundus – below umbilicus? Firm? Tender?
    - Perineum: Assess lochia (blood on pad, how old is pad?)
      Visually inspect perineum – Hematoma? Edema? Sutures intact?
    - Extremities: Edema? Cords? Tender?
- Postpartum labs: Hemoglobin or hematocrit

Assessment/Plan: PPD#_ S/P NSVD or Vacuum or Forceps (with 4th-degree laceration, with pre-eclampsia s/p Magnesium Sulfate)

- General assessment – Afebrile, doing well, tolerating diet
- Contraception plans (must discuss before patient goes home)
- Vaccines – does pt need rubella vaccine prior to discharge?
- Breastfeeding? Problems? Encourage.
- Rhogam, if Rh-negative
- Discharge and follow-up plan
- Patients usually go home if uncomplicated 24-48 hours postpartum
- Follow-up appointment scheduled in 2-6 weeks postpartum

4b. Sample Postoperative Cesarean Section Orders/Note

Sample C/S Orders

Admit to Recovery Room, then postpartum floor
Diagnosis: Status post (s/p) C/S for failure to progress (FTP)
Condition: Stable
Vitals: Routine, q shift
Allergies: None
Activity: Ambulate with assistance this PM, then up ad lib
Nursing: Strict input and output (I&O), Foley to catheter drainage, call MD for Temp > 38.4, pulse > 110, BP < 90/60 or > 140/90, encourage breastfeeding, pad count, dressing checks, and Ted's leg stockings until ambulating
Diet: Regular as tolerated; some hospitals only allow ice chips or clear liquids
IV: Lactated ringers (LR) or D5LR at 125 cc/hr, with 20 units of Pitocin x 1-2 Liters
Labs: CBC in AM
Medications:

- Morphine sulfate PCA (patient controlled analgesia) per protocol (1 mg per dose with 10 minute lockout, not to exceed 20 mg/4 hours)
- Percocet 1-2 tabs PO q 4-6 hours prn pain, when tolerating PO well
- Vistaril 25 mg IM or PO q 6 hours prn nausea
- Ibuprofen 800 mg PO q 8 hours prn pain, when tolerating PO well
- Prophylactic antibiotics if indicated
- Thromboprohylaxis for high-risk patients
- Rhogam, if Rh-negative

Sample C/S Note

Date and Time:
Day #1 (Post-op day POD#1)
Subjective: Ask patient about:

- Pain – relieved with medication?
- Nausea/vomiting
- Passing flatus (rare this early post-op)

Objective:

- Vital signs and note tachycardia, elevated or low BP, maximum and current temperature
- Input and output

- Focused physical exam including
  - Heart
  - Lungs
  - Breasts: engorged? Nipples – Is skin intact?
  - Incision: Clean and dry, intact?
  - Abd: Soft? Location of the uterine fundus – below umbilicus? Firm? Tender?
  - Perineum: Assess lochia (blood on pad, how old is pad?)
    Visually inspect perineum – Hematoma? Edema? Sutures intact?
  - Extremities: Edema? Cords? Tender?
- Postpartum labs: Hemoglobin or hematocrit

Assessment/Plan: POD#1 status post (S/P) C/S or repeat C/S (indication for the C/S)

- Afebrile, tolerating pain with medication, oral intake, adequate urine output (>30cc/hr)
- Routine post-op care
  - Discharge Foley
  - Discharge PCA or IV pain medications and PO pain Meds when tolerating PO
  - Out of bed (OOB)
  - Advance diet as tolerated
  - Discharge IV when tolerating PO
- Check hematocrit or CBC

5. Sample Gynecologic History and Physical

Introduction: Name, age, gravidity, parity and presenting problem
HPI:
Past Medical History/Past Surgical History:
Past Gynecologic History:

- Menses – menarche, cycle duration, length, heaviness, intermenstrual bleeding, dysmenorrhea, and menopause (if relevant).
- Abnormal Pap smears, including time of last Pap
- Sexually transmitted infections
- Sexual history
- Postmenopausal women. Ask about hypoestrogenic symptoms, such as hot flashes or night sweats, vaginal dryness, and about current and past use of hormone/estrogen replacement therapy.
- Mammogram

Past OB History: Date of delivery, gestational age, type of delivery, sex, birthweight and any complications
Family History:
Allergies:
Medications:
Social History:
Physical Exam: Complete
Review of Systems:
Plan:

1. Pap smear
2. Endometrial biopsy obtained
3. Medications, etc.

Two Sample Gyn Clinic SOAP Notes

S. 22 y/o G2P2 here for annual exam. Regular menses q 28 days with no intermenstrual bleeding. IUD for contraception since birth of last child 2 years ago. No problems with method. Minimal dysmenorrhea. Mutually monogamous relationship x 6 years. No hx of abnormal Paps. + BSE, jogs twice a week, no smoking, no abuse, + seat belts.

O. Breasts: No masses, adenopathy, skin changes
Abd: No masses, soft, NT
Pelvic:
Ext genitalia: Normal
Vagina: pink, moist, well rugated
Cervix: multiparous, no lesions
Bimanual: uterus small, anteverted, NT, no adnexal masses or tenderness

A. Normal exam
P. Pap, RTC 1 year

* * * *

S. 33 y/o G3P1 with LMP 1 week ago here for follow up of chronic left sided pelvic pain. Patient first seen 6 months ago with complaints of pain x 2 years. She describes pain as dull and aching, intermittent, with no relationship to eating but increased before and during menses. Pain has gotten worse over the last 6 months and requires her to miss work 2-3 days per month. No relief with NSAIDs. Patient has history of

chlamydia 5 years ago for which she was treated. No history of PID. Three partners within the past year: no condom use No GI symptoms: regular BMs, no constipation, diarrhea, nausea or vomiting. Past history of ectopic x 2 with removal of part of the left and right tubes. Also had ruptured appendectomy at age 20. On birth control pills for contraception.

O. Abdomen: 1+ LLQ tenderness, no peritoneal signs
Pelvic: Ext genitalia: Normal
Vagina: no discharge
Cervix: no lesions
Biman: uterus small, retroverted, NT, 3+ left adnexal tenderness, no right adnexal tenderness, no masses palpated

A. Pelvic pain unresponsive to medical management; rule out endometriosis vs adhesive disease vs chronic PID vs other

P. Schedule diagnostic laparoscopy

6. Admission Orders

These vary a little from case to case, but the following are fairly general (format is ADC VAN DISMAL):

Admit:	To the specific service or team
Diagnosis:	List the diagnosis and the names of any associated surgeries or procedures
Condition:	Such as Stable vs Fair vs Guarded
Vitals:	Frequency
Activity:	Ambulation, showering
Nursing:	Foley catheter management parameters
	Prophylaxis for deep venous thrombosis
	Incentive spirometry protocols
Call orders	Vital sign parameters for notifying the team
	Urine output parameters
Diet:	Oral intake management
IVF:	Rates are typically set at 125 cc per hour
Special:	Drain management
	Oxygen management
Meds:	Pain medications
	Prophylactic orders, such as for sleep or nausea
	The patients' regular medications
Allergies:	
Labs:	Typically includes hemoglobin/hematocrit

7. Commonly-Used Abbreviations

AB	abortion MAB - missed abortion SAB - spontaneous abortion TAB - therapeutic abortion EAB - elective abortion
ACOG	American College of Obstetricians and Gynecologists
AFP	Alpha Fetoprotein MSAFP - maternal serum alpha-fetoprotein
AGUS	atypical glandular cells of unknown significance
AMA	advanced maternal age
AFI	amniotic fluid index
APGO	Association of Professors of Gynecology & Obstetrics
AROM	artificial rupture of membranes
ASCUS	atypical squamous cells of unknown significance
BBOW	bulging bag of water
BBT	basal body temperature
BMD	bone mineral density
BPD	biparietal diameter
BPP	biophysical profile
BSO	bilateral salpingo-oophorectomy
BTBV	beat-to-beat variability
BTL	bilateral tubal ligation
CIN	cervical intraepithelial neoplasia
CPD	cephalopelvic disproportion
CRL	crown rump length
CST	contraction stress test
CT	chlamydia trachomatous
CVS	chorionic villi sampling
D & C	dilatation & curettage
D & E	dilatation & evacuation
DIC	disseminating intravascular coagulopathy
DI/DI	dichorionic/diamniotic twins
EDC/EDD	estimated date of confinement/estimated date of delivery
EFM	electronic fetal monitoring
EFW	estimated fetal weight
EGA	estimated gestational age
EMB	endometrial biopsy
ERT	estrogen replacement therapy
FAVD	forceps assisted vaginal delivery
FHR/FHT	fetal heart rate/fetal heart tracing or tone
FL	femur length
FLM	fetal lung maturity
FM	fetal movement
FSE	fetal scalp electrode
FSH	follicle stimulating hormone
FTP	failure to progress
GBS/GBBS	group B beta streptococcus
GC	gonorrhea
GDM	gestational diabetes mellitus

GIFT	gamete intra-fallopian tube transfer
GnRH	gonadotropin releasing hormone
G_P_	gravida, para (TPAL - term, preterm, abortions, living children)
GTD	gestational trophoblastic disease
HCG	human chorionic gonadotropin
	BHCG - beta human chorionic gonadotropin (usually serum)
	UHCG - urinary human chorionic gonadotropin
HELLP	hemolysis, elevated liver enzymes, low platelets
HGSIL	high-grade squamous intraepithelial lesion
HPL	human placental lactogen
HPV	human papilloma virus
HRT	hormone replacement therapy
HSG	hysterosalpingogram
HSV	herpes simplex virus
I & D	incision & drainage
ICSI	intracytoplasmic sperm injection
IUD	intrauterine device
IUFD	intrauterine fetal death
IUGR	intrauterine growth retardation
IUI	intrauterine insemination
IUP	intrauterine pregnancy
IUPC	intrauterine pregnancy pressure catheter
IVF	in vitro fertilization
LCP	long, closed, posterior
LEEP/LOOP	loop electrical excision procedure
LGA	large for gestational age
LGSIL	low grade squamous intraepithelial lesion
LH	luteinizing hormone
LMP/LNMP	last menstrual period/last normal menstrual period
LOA/LOT/LOP	left occiput anterior/left occiput transverse/left occiput posterior
LTC	long, thick, closed
LTCS/LVCS	low transverse C- section/low vertical C-section
MFM	maternal fetal medicine
MVU	Montevideo units
NST	non-stress test
NSVD	normal spontaneous vaginal delivery
NT	nuchal translucency
NTD	neural tube defect
OCP	oral contraceptive pills
OT	occiput transverse
PCO/PCOD	polycystic ovarian disease
PCT	post-coital testing
PID	pelvic inflammatory disease
PIH	pregnancy induced hypertension
PMB	postmenopausal bleeding
POC	products of conception
POD/PPD	post-operative day/postpartum day
PPH	postpartum hemorrhage
PPROM	preterm premature rupture of membranes
PROM	premature rupture of membranes
PTL	preterm labor

PUBS	percutaneous umbilical blood sampling
PUPPPS	pruritic urticarial papules and plaques of pregnancy
ROA/ROT/ROP	right occiput anterior/right occiput transverse/right occiput posterior
ROM	rupture of membranes
SBE	self breast exam
SGA	small for gestational age
SROM	spontaneous rupture of membranes
SSE	sterile speculum exam
STD/STI	sexually transmitted disease/sexually transmitted infection
SVE	sterile vaginal exam
TAH	total abdominal hysterectomy
TOA	tubo-ovarian abscess
TOL	trial of labor
TRIPLE TEST	MSAFP/HCG/Estriol
TVH	total vaginal hysterectomy
US	ultrasound
VAVD	vacuum-assisted vaginal delivery
VB	vaginal bleeding
VBAC	vaginal birth after C-section
VAIN	vaginal intraepithelial neoplasia
VIN	vulvar intraepithelial neoplasia

8. Spanish Lesson

Admission History and Physical

My name is ....Me llamo

What is your name?...¿Como se llama usted?

What number pregnancy is this for you? ....¿Que numeró embarazó es este para usted?

First?...¿Primero?

Second? ....¿Segundo?

Third?..¿Tercero?

What is your due date?..¿Cual es su fecha de alivio?

Have you had ultrasounds?..¿Ha tenido sonogramas?

How many?...¿Cuantas?

How frequent are your contractions?....................................¿Que frecuenté son suscontriciones

When did they start? ....¿Cuando comenzaron?

Has your bag of waters broken?..¿Se le ha roto la fuente / la bolas de agua?

What color was the fluid?...¿De que color era el fluido?

Are you bleeding? ....¿Se la ha salido sangre?

How much?..¿Cuanto?

What color?..¿De que color?

Have you passed any mucous?..¿Se la ha salido moco o flujo?

Do you have any serious illnesses?...¿Tiene usted una enfermedad seria?

Have you had any operations? ....¿Ha tenido usted operaciones (cirugía)?

Are you taking any medicine?...¿Usted tome cualquier tipo de medicina?

Are you allergic to any medications? ....¿Tiene usted alergia a cualquier medicina?

Foods?..¿Comidas?

Have you been tested for diabetes this pregnancy? ....¿Le han hecho examinaciones de la sangre para la diabetes este embarazo?

Any spotting/bleeding this pregnancy? ....¿Le ha salido gotas de sangre o hemorragias con este embarazo?

How much do you weigh now?...¿Cuanto pesa usted ahora?

Do you smoke? ....¿Fuma usted?

How much?..¿Cuanto?

Breast or bottle feeding?...¿Le va dar de pecho o de biberón?

Labor

English	Spanish
We need to do a vaginal exam.	Tenemos que hacer una examinación vaginal.
Your cervix is __ centimeters dilated.	El cuello de la matriz esta abierto __ centímetros.
Do you want some pain medication?	¿Quiera usted medicina ara el dolor?
You need to relax and breathe with the contractions.	Usted necesita relajarse con los dolores.
We are going to break your bag of waters.	Vamos a romper su fuente, (bolsa de agua).
We need to make your contractions more frequent	Vamos a darle medicina para que le da contracciones mas frecuenta.
Do you feel rectal pressure with the contractions?	¿Cuando le da los dolores, siente presión in el recto?
Do you feel the urge to push?	¿Siente usted como que necesita pujar?
Your cervix is completely dilated. It is time to push.	El cuello de la motriz esta totalmente abierto. Es tiempo pujar.
Take deep breaths.	Respire profundo.
Hold it (your deep breath).	Detenga su aire.
Put your chin on your chest.	Ponga su cabeza en su pecho.
Push downward (on your bottom) like you are having a bowel movement.	Puje para abajo como si va a regir.
Put your hands on your knees and pull them back towards you.	Pone sus manos en sus rodillas y jale hacia usted.
Push very hard.	Puje muy fuerte.

Delivery

English	Spanish
Don't push now.	No puje ahora.
Slow (pant) with your contractions.	Sople con sus contracciones
It's a boy/girl!	¡Es un niño / una niña!
Push for the placenta.	Puje para la placenta.
Relax, let your legs fall to the sides.	Relájese y deje que se caen sus piernas a los lados.
We are sewing up your episiotomy.	Vamos a poner puntos donde le cortando.
We're going to give you medicine through your IV to stop your contractions.	Vamos a darle medicina en la sonde para que se paren los dolores.
We need to do an ultrasound.	Necesitamos hacer una sonograma.
Your baby is coming: head/bottom/feet first.	Su bebe viene: cabeza/nalga/pies primero.
Your blood pressure is high.	Su presión esta alta.
Tell me immediately if you have a headache,	Dígame inmediatamente si tiene blurred vision, or epigastric pain dolor de cabeza, la vista rrosa vista doble, o dolor en el estomago.
This is a consent for a Cesarean section.	Esta es un permiso para una cesaría.