The gynaecological history and examination
* patient's name
* Age
* Occupation
* Residence
* Religion
* Marital status
* Blood group
Chief complaint: a brief statement of the general nature and duration of the main complaint.
History of presenting complaint: this section should focus on the presenting complaint, but certain important points should always be enquired about:

* Abnormal menstrual loss.
* Pattern of bleeding- regular or irregular.
* Intermenstrual bleeding.
* Amount of blood loss- great or less than usual.
* Number of sanitary towels or tampons used.
* Passage of clots or flooding.
* Pelvic pain-site of pain, nature, and relation to periods.
* Anything that aggravates or relieves the pain, radiation of pain, associated symptoms.
* Vaginal discharge- amount, colour, odour, presence of blood.

Obviously if the presenting complaint is one of subfertility or is urogynecological, the history must be appropriately tailored.
Review of other systems:
  * Appetite, weight loss or gain.
  * Bowels, micturition.
  * Cardiovascular, respiratory and other systems.
Usual menstrual cycle:

* Age of menarche.
* Usual duration of each period and length of cycle.
* Painful cycles.
* First day of the last period.
* Age of menopause.
Previous gynaecological history:

* Previous gynaecological surgery or treatment.
* The date of last cervical smear.
* History of discomfort, pain, or bleeding during intercourse.
* The use of contraception and type of contraception used.
* History of infertility.
Previous obstetric history:

* Number of children with ages and birth weights.

* Any abnormalities with pregnancy, labour or the puerperium.

* Number of miscarriages and gestation at which they occurred.

* Any termination of pregnancy with record of gestation age and any complications.
Previous medical history:
  * Any serious illness or medical disease.

Previous surgical history:
  * Previous operations.
  * blood transfusion.
Family history:
* Any medical diseases.
* History of gynaecological or obstetric conditions.

Drug history:
* Allergy to drugs.
* Current drug use.
Social history:

* Smoking and alcohol use.
* Marital status.
* Family problems.
Examination:

General examination:
General look: ill, well, body built.
Hands and mucous membranes for anaemia, cyanosis, jaundice.
Lymph nodes particularly the left supraclavicular node where, in cases of abdominal malignancy one might palpate the enlarged Virchow's node (Troissier's sign).
Thyroid gland should be palpated.
Chest and breast for tumour, pleural effusion.
Abdominal examination:

*Inspection:*
The contour of the abdomen for any distension or mass
Surgical scars, dilated veins or striae gravidarum
Laparoscopy scars, pfannenstiel scars
The patient is asked to cough or raise her head for any herniae, divarication of the rectus muscles
Hair distribution, umbilicus
**Palpation:**

- First, if the patient has any pain, she should be asked to point to the site. This area should not be examined until the end of palpation.

- Using the right hand, examine the left lower quadrant and proceed to the right lower quadrant.

- Palpate for masses, liver, spleen, and kidneys.

- If a mass is present but it is possible to palpate below, it is more likely to be an abdominal mass. In case of a pelvic mass, one cannot palpate below it.

- Signs of peritonism: guarding and rebound tenderness.

- Examination for inguinal herniae and lymph nodes.
Percussion:
Shifting dullness, ascitic fluid will settle down into a horseshoe shape and dullness in the flanks can be demonstrated, as the patient moves over to her side the dullness will move to her lowermost side. A fluid thrill can also be elicited.

An enlarged bladder due to urinary retention will also be dull to percussion.

Auscultation:
Postoperative patient listen for bowel sounds.
Pelvic examination:

Patient's verbal consent and a female chaperone should be present for any intimate examination.

The external genitalia are first inspected under good light with the patient in dorsal position, the hips flexed and abducted and the knees flexed.

The left lateral position is used for examination of prolapse or to inspect the vaginal wall with a Sim's speculum.

The patient is asked to strain down to detect any prolapse and also to cough, as this will show the sign of stress incontinence.
Figure 1.2 (a) Sims’ speculum. (b) Sims’ speculum exposing anterior vaginal wall.
Cusco's bivalve speculum is inserted to visualize the cervix (after warming it) a smear test could be performed at the same time.
Bimanual digital examination using the fingers of the right hand in the vagina and the left hand on the abdomen, the cervix is palpated for hardness or irregularity. The size, shape, position, mobility, and tenderness of the uterus. The adnexae are examined on each side. The uterosacral ligaments are palpated for scarring or shortening as in endometriosis.
Figure 1.4 (a) Bimanual examination of the pelvis, assessing uterine size. (b) Examining the lateral fornix.
In a virgin or a child, only rectal examination should be performed, also useful to differentiate between enterocele and rectocele and could be used to assess the size of a rectocele
Thank you