Outpatient Hysteroscopy History Sheet

Affix Patient ID Label

Source of Referral: (please tick)

□ GP
□ Consultant
□ Colposcopy
□ Other (please specify)

Presenting Complaint:
Eg. HMB, IMB, PCB, misplaced coil, failed endometrial biopsy

Age

BMI

Menstrual Cycles: (please tick)
Cycle Length……
Bleed Duration…….
□ Regular □ Irregular
□ Heavy
□ Flooding and clots
□ Dysmenorrhoea
□Dyspareunia

LMP:

Previous Treatment Trials:

Past Medical History:

Past Surgical History (relevant, gynae etc)**:**

Alcohol
Smoker / Non-smoker

Drug History:

HRT:

Coagulants:
Drug Allergies:

Parity:
Number of Caesarean Sections:
Number of Vaginal Deliveries:

Contraception:

Pregnancy Diagnostic Test:
□ Positive
□ Negative

Ultrasound Scan: (please tick)
□ TAUS □ TVUS

Uterine attitude:

Uterine pathology:

Endometrial thickness (mm):

Ovaries:

Smears: (please tick)

□ Up-to-date
□ Normal
□ Abnormal
□ Previous Colposcopy
Details:

Abdominal Examination: Yes / No Findings:

Mental Capacity concerns: Yes / No

Performance Status: (tick)
□ **1** Fully active
□ **2** Able to carry out light work
□ **3** Up and about 50% of waking time
□ **4** Limited self care, confined to bed/chair 50%
□ **5** No self care, confined to bed/chair 100%

Proceed to Hysteroscopy: Yes / No

Date:	Signature:
Time:	Print:
	Designation:

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Consent: (please tick)

□ Verbal for Vaginal +/- Speculum Examination

□ Written / E Consent for OPH +/- biopsy +/- treatment +/- insertion IUS

□ Option for GA discussed

Procedure: (please tick)

Type of Scope:
□ Rigid □ Flexi

Cervical block given: Yes / No (see drug card)

Vaginoscopic approach: Yes / No

Findings:
Vulva ……..
Vagina ……
Cervix …….

Uterine view: (tick)
□ Good
□ Poor

Tubal ostia seen: (tick)
□ Right
□ Left

Endometrium: (tick)
□ Normal □ Atrophic □ Haemorrhagic
……
……
……

Uterine Pathology:
□ **Fibroids:**
Type (circle) 0 1 2

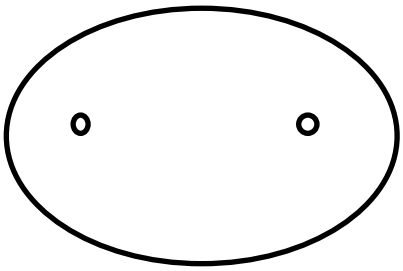
Number: ……
Appearance: ……
Location: ……

□ **Polyps:**
Number: ……
Appearance:……..
Location: ……

□ **Synechiae:**

□ **Other Findings:**

Diagram:



Actions: (please tick)

□ Uterine Cavity Length ……

□ Biopsy:
□ Directed □ Pipelle □ Syringe

□ Polypectomy

□ Insertion of IUD
Type: ……
Expiry:……

□ Smear Test: Yes / No

Care Plan: (please tick)

□ Await histology results and write to patient
□ Reassured and Discharged
□ Placed on waiting list for Hysteroscopy +/- treatment under GA
□ Placed on waiting list for OPH Myosure
□ MRSA swabs taken
□ MDT referral
□ Gynae Outpatient Follow up
□ Referral to Colposcopy

Date:	Signature:
Time:	Print:
	Designation: