OBSTETRIC HISTORY AT A GLANCE

GTPAL *gravida · term · preterm · abortions · living*

The five-character shorthand every L&D and prenatal nurse uses to document reproductive history, stratify risk, and anticipate complications — from uterine atony in the grand multipara to recurrence prevention in the previous preterm mother.

SYSTEM · REPRODUCTIVE | PRIORITY · RISK ID | TEST FOCUS · CALCULATION

01 Definition & Why It Matters

the nurse's risk lens before every prenatal visit

What it is A

A 5-letter coding system used to summarize a pregnant patient's complete obstetric history — past pregnancies, outcomes, and currently living children.

When it's used B

Every prenatal visit, every L&D admission, every postpartum assessment. Also recorded on intake at any ED visit during pregnancy.

Why it matters C

Flags high-risk patients: grand multipara (PPH risk), history of preterm (recurrence risk), repeated losses (cervical insufficiency workup).

02 Letter-by-Letter Breakdown

memorize the weeks — NCLEX will test them

G — GRAVIDA

ALL PREGNANCIES

# of times pregnant. Counts **current** pregnancy, multiples as one, ectopics, and losses.

T — TERM

≥ 37 0/7 WKS

of **babies** born at 37 weeks or later — live or stillborn.

P — PRETERM

20 0/7 – 36 6/7

of **babies** born between 20 and 36 6/7 weeks.

A — ABORTIONS

< 20 WKS

Any pregnancy ended before 20 weeks — spontaneous, elective, or **ectopic**.

L — LIVING

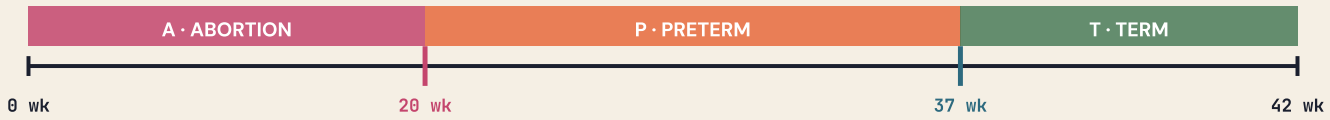
ALIVE TODAY

# of children **currently living** — not the number delivered alive.

Pregnancies vs. Babies — the decoder ring

G counts PREGNANCIES → Twins = **1 G** · T & P count BABIES → Twins at 36 wks = **2 P** · L counts LIVING NOW

The 20-week cutoff — miscarriage vs. preterm



Stillbirth ≥ 20 wks = Preterm/Term (NOT Abortion, NOT Living)

03 Red Flag Patterns in GTPAL

when the numbers predict a high-risk pregnancy

Grand Multipara · G ≥ 5

Five or more pregnancies carried beyond 20 weeks. **High risk for uterine atony & postpartum hemorrhage** from overstretched, fatigued myometrium. Prepare oxytocin, large-bore IV, blood on standby.

Previous Preterm · P ≥ 1

A history of preterm birth is the single **strongest predictor** of another preterm birth. Candidate for weekly progesterone (17P) starting at 16 weeks and cervical length surveillance.

⚠ Recurrent Losses · A ≥ 2–3

Triggers workup for **cervical insufficiency, antiphospholipid syndrome, thyroid disease, and uterine anomalies**. May warrant prophylactic cerclage at 12–14 weeks.

⚠ L < (T + P)

The patient has lost a child after delivery. **Psychosocial priority** — acknowledge grief, assess coping, refer to bereavement support. Do NOT gloss over this on intake.

Nullipara · G = 1, T = 0, P = 0

First pregnancy currently in progress. **Higher risk for prolonged labor, preeclampsia, and failure to progress.** Extra education need for labor expectations.

⚠ History of Ectopic · counted in A

Ectopic pregnancies count under **A**, not their own letter. Increases risk of recurrent ectopic — **early first-trimester ultrasound is priority** to confirm intrauterine implantation.

04 Priority Nursing Interventions

assess → calculate → flag → plan

1 ASSESS obstetric history
Open the visit with *"Have you ever been pregnant before?"* Use open-ended prompts. Clarify multiples, losses, ectopics, and terminations sensitively.

2 CALCULATE accurately
Walk through each letter methodically. Twins = 1 G but 2 T or P. Current pregnancy adds to G only. Loss at exactly 20 wks = Preterm, not Abortion.

3 DOCUMENT in the chart
Format as G_T_P_A_L_. Example: G4 T1 P2 A1 L2. Verify at each visit — pregnancies can be added, lost, or delivered.

4 IDENTIFY risk factors
Flag grand multipara, previous preterm, recurrent losses, and fetal demise. Trigger the appropriate workup or referral. Pin to handoff report.

5 PREPARE for delivery risks
Grand multipara: have oxytocin, methylergonovine, large-bore IV, T&S ready. Previous PPH is the single biggest predictor of another.

6 PROVIDE psychosocial support
If L < (T+P) or history of loss: pause, acknowledge, offer chaplain/bereavement, and **do not force disclosure** beyond what's needed.

05 Pharmacology Tied to GTPAL Risk

what you give based on what the numbers show

Oxytocin · Pitocin

UTEROTONIC · POSTPARTUM

Use: 1st-line PPH prevention, especially in grand multipara (G ≥ 5).

Key SE: Hypotension, water intox, uterine hyperstim.

Nurse: 10–40 units in 1 L LR; monitor fundal tone & bleeding q15 min ×1 hr.

`INDICATION: G ≥ 5, prior PPH`

17-OH Progesterone · Makena

HORMONE · PRETERM PREVENTION

Use: Prior spontaneous preterm birth (P ≥ 1) with singleton pregnancy.

Key SE: Injection site pain, mood changes, possible glucose intolerance.

Nurse: IM weekly from 16 wks through 36 6/7 wks.

`INDICATION: P ≥ 1 (singleton)`

Rho(D) Ig · RhoGAM

IMMUNE GLOBULIN

Use: Rh-negative mother to prevent isoimmunization — after any A (ectopic, miscarriage, abortion), at 28 wks, and postpartum.

Key SE: Mild injection site reaction, low-grade fever.

Nurse: 300 mcg IM within 72 hrs of exposure or 28-wk dose.

`INDICATION: Any A in Rh- mom`

06 NCLEX Test Traps ⚠

the exact wrong answers NCLEX wants you to pick

TRAP ~~Twins born at 36 wks count as **2 pregnancies** (G = 2).~~	TRUTH Multiples = 1 pregnancy (1 G) but 2 babies under P.
TRAP ~~"Abortion" on the NCLEX always means elective termination.~~	TRUTH Abortion = any loss < 20 wks — miscarriage, elective, ectopic, molar.
TRAP ~~A stillbirth at 32 weeks counts under A (abortion).~~	TRUTH ≥ 20 wks = Preterm (P). Stillborn does NOT go under L.
TRAP ~~Miscarriage at exactly 20 weeks = Abortion.~~	TRUTH 20 wks and beyond = Preterm. The cutoff is strictly < 20 wks for A.
TRAP ~~Living = number of babies ever born alive.~~	TRUTH Living = children alive right now. If one died at age 5, L drops by 1.
TRAP ~~Current pregnancy counts in T, P, A, and L.~~	TRUTH Current pregnancy counts in G only — it's not yet born or lost.
TRAP ~~Ectopic pregnancy gets its own letter or isn't counted.~~	TRUTH Ectopic counts in G and A. It's a pregnancy that ended < 20 wks.

07 Patient Education & Communication

trauma-informed, confidential, judgment-free

- **Explain the purpose.** "These questions help us plan the safest care for you and this baby — including medications and specialists you might need."
- **Encourage honesty.** A prior ectopic, D&C, or preterm birth changes your risk profile and your plan — don't omit.
- **Clarify terminology.** Patients often use "miscarriage" and "abortion" differently than clinicians. Ask what *they* mean.
- **Reassure confidentiality.** Especially around terminations, losses, or paternity — this is protected medical information.
- **Normalize losses.** About 1 in 4 pregnancies ends in loss. Acknowledge grief; offer bereavement, chaplain, or support group resources.
- **Set expectations by risk.** Grand multipara: faster labor, higher PPH risk. Prior preterm: more frequent US & 17P injections.

08 Memory Boosters & Mnemonics

lock it in before the exam

GTPAL · the obstetric alphabet

G T P A L

Girls Take Plenty A Liters

```
T + P + A = G - (1 if currently pregnant)
```

If the total doesn't add up, you forgot the current pregnancy in G — or mis-classified the 20-week cutoff.

G = PREGNANCIES · T & P = BABIES · L = ALIVE NOW

The single most tested distinction. Twins: 1 pregnancy, 2 babies, 2 living (if alive today).

Worked Example · the NCLEX-style vignette

SOLVE IT

Maria, currently 28 weeks pregnant, reports: twin girls delivered at 36 weeks (both alive and well), a miscarriage at 10 weeks, and a son born at 40 weeks who died in a car accident at age 3. What is her GTPAL?

G	T	P	A	L
4	1	2	1	2
current + twin preg + miscarriage + son	son at 40 wks	twins at 36 wks (2 babies)	miscarriage < 20 wks	twin girls alive today