



## OSCE Checklist: Breast Lump History Taking

| Opening the consultation          |   |
|-----------------------------------|---|
| 1                                 | Wash your hands and don PPE if appropriate  |
| 2                                 | Introduce yourself to the patient including your name and role  |
| 3                                 | Confirm the patient's name and date of birth  |
| 4                                 | Explain that you'd like to take a history from the patient  |
| 5                                 | Gain consent to proceed with taking a history   |
| Presenting complaint              |   |
| 6                                 | Use open questioning to explore the patient's presenting complaint  |
| History of presenting complaint   |   |
| 7                                 | Site: ask where the breast lump is  |
| 8                                 | Onset: clarify when the breast lump first developed   |
| 9                                 | Character: ask the patient to describe how the breast lump feels  |
| 10                                | Radiation: if pain is associated with the breast lump, ask if it radiates                                 |
| 11                                | Associated symptoms: ask if there are any other associated symptoms                                       |
| 12                                | Time course: ask how the breast lump has changed over time  |
| 13                                | Exacerbating or relieving factors: ask if anything makes the breast lump worse or better                  |
| 14                                | Severity: assess the severity of any associated pain by asking the patient to grade it on a scale of 0-10 |
| 15                                | Screen for other key symptoms including red flag features   |
| 16                                | Explore the patient's ideas, concerns and expectations  |
| 17                                | Summarise the patient's presenting complaint  |
| Systemic enquiry                  |   |
| 18                                | Screen for relevant symptoms in other body systems  |
| Past medical and surgical history |   |
| 19                                | Ask if the patient has any medical conditions   |
| 20                                | Ask if the patient has had any relevant surgical procedures   |
| 21                                | Take a brief obstetric and gynaecology history for breast cancer risk factors                             |
| 22                                | Ask if the patient has any allergies and if so, clarify what kind of reaction they had to the substance   |
| Drug history                      |   |
| 23                                | Ask if the patient is currently taking any prescribed medications or over-the-counter remedies            |

| Family history           |   |
|--------------------------|---|
| 24                       | Ask the patient if there is any family history of breast, bowel or ovarian cancer                             |
| Social history           |   |
| 25                       | Explore the patient's general social context  |
| 26                       | Take a smoking history  |
| 27                       | Take an alcohol history   |
| 28                       | Ask about recreational drug use   |
| 29                       | Gather details about the patient's occupation   |
| Closing the consultation |   |
| 30                       | Summarise the salient points of the history back to the patient and ask if they feel anything has been missed |
| 31                       | Thank the patient for their time  |
| 32                       | Dispose of PPE appropriately and wash your hands  |
| Key communication skills |   |
| 33                       | Active listening  |
| 34                       | Summarising   |
| 35                       | Signposting   |

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