OSCE Checklist: Gynaecological 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	
6	Confirm last menstrual period, gravidity and parity early on in the consultation	
Presenting complaint		
7	Use open questioning to explore the patient's presenting complaint	
History of presenting complaint		
8	Site: ask where the symptom is (if relevant)	
9	Onset: clarify when the symptom first started and if it the onset was sudden or gradual	
10	Character: ask the patient to describe how the symptom feels	
11	Radiation: ask if the symptom moves anywhere else	
12	Associated symptoms: ask if there are any other associated symptoms	
13	Time course: ask how the symptom has changed over time	
14	Exacerbating or relieving factors: ask if anything makes the symptom worse or better	
15	Severity: ask how severe the symptom is on a scale of 0-10	
16	Screen for other key gynaecological symptoms (e.g. abdominal pain, pelvic pain, post-coital bleeding, intermenstrual bleeding, post-menopausal bleeding, abnormal vaginal discharge, dyspareunia, vulval skin changes, vulval pruritis, fatigue, fever, weight loss)	
17	Explore the patient's ideas, concerns and expectations	
18	Summarise the patient's presenting complaint	
Systemic enquiry		
19	Screen for relevant symptoms in other body systems	
Menstrual history		
20	Ask about the duration of menstruation	
21	Ask about the frequency of menstruation	
22	Ask about the volume of menstruation	
23	Ask about dysmenorrhoea	
24	Ask the patient when the first day of their last menstrual period was (if not done already)	
25	Ask the patient how old they were when they started having periods and (if relevant) when they went through the menopause	

Contraception		
26	Clarify the type of contraception currently used	
27	Explore the patient's previous contraception history	
Reproductive plans		
28	Ask if the patient is considering having children in the future	
Past gynaecological history		
29	Ask if the patient has previously had any gynaecological problems	
30	Ask the patient if they've previously undergone any surgery or procedures in the past	
31	Clarify the patient's cervical screening history	
Past medical history		
32	Ask if the patient has any medical conditions	
33	Ask if the patient has any allergies and if so, clarify what kind of reaction they had to the substance	
Obstetric history		
34	Clarify the patient's gravidity and parity (if not done already)	
35	Gather key details about the patient's current pregnancy (if relevant)	
36	Gather key details about the patient's previous pregnancies (if relevant)	
Drug history		
37	Ask if the patient is currently taking any prescribed medications or over-the-counter remedies	
Family history		
38	Ask if there is any family history of malignancy, bleeding disorders and blood clots.	
Social history		
39	Explore the patient's general social context (accommodation, who the patient lives with, support)	
40	Take a smoking history	
41	Take an alcohol history	
42	Ask about recreational drug use	
43	Ask about diet, weight and occupation	
44	Ask about domestic abuse	
Closing the consultation		
45	Summarise the salient points of the history back to the patient and ask if they feel anything has been missed	
46	Thank the patient for their time	
47	Dispose of PPE appropriately and wash your hands	

Key communication skills		
48	Active listening	
49	Summarising	
50	Signposting	