OSCE Checklist: Obstetric 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 gestational age, 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 obstetric symptoms (e.g. nausea, vomiting, reduced fetal movements, vaginal bleeding, abdominal pain, vaginal discharge or fluid loss, headaches, visual disturbance, epigastric pain, oedema, pruritis, unilateral leg swelling, chest pain, shortness of breath, 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	
Current pregnancy		
20	Clarify the current gestational age of the pregnancy (if not done already)	
21	Ask about recent scan results	
22	Ask about screening	
23	Ask about immunisations	
24	Ask about maternal mental health	

25	Clarify other details of the current pregnancy (e.g. singleton vs multiple gestation, use of folic acid, mode of delivery, medical illness during pregnancy)	
Previous obstetric history		
26	Clarify the patient's gravidity and parity (if not done already)	
27	For term pregnancies (>24 weeks) clarify: gestation at delivery, birth weight, mode of delivery, complications, stillbirths, use of assisted reproductive techniques	
28	Ask sensitively about miscarriages, termination of pregnancy and ectopic pregnancy	
Gynaecological history		
29	Ask about recent and previous cervical screening results	
30	Ask about previous gynaecological conditions and treatments	
Past medical history		
31	Ask if the patient has any medical conditions	
32	Ask the patient if they've previously undergone any surgery or procedures	
33	Ask if the patient has any allergies and if so, clarify what kind of reaction they had to the substance	
Drug history		
34	Ask if the patient is currently taking any prescribed medications or over-the-counter remedies	
35	Ask if the patient was using contraception prior to falling pregnant and if this has stopped/ removed (e.g. coil, implant)	
Family history		
36	Ask if there is any family history of genetic conditions, type 2 diabetes or pre-eclampsia	
Social history		
37	Explore the patient's general social context (accommodation, who the patient lives with, support)	
38	Take a smoking history	
39	Take an alcohol history	
40	Ask about recreational drug use	
41	Ask about diet, weight and occupation	
42	Ask about domestic abuse	
Closing the consultation		
43	Summarise the salient points of the history back to the patient and ask if they feel anything has been missed	
44	Thank the patient for their time	
45	Dispose of PPE appropriately and wash your hands	

Key communication skills		
46	Active listening	
47	Summarising	
48	Signposting	