OSCE Checklist: Ophthalmic 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	Ask which eyes are affected (i.e. one or both)	
8	Ask about when and how the problem started (including history of trauma)	
9	Ask about key ophthalmic symptoms (e.g. visual disturbance, red eye, discharge/watering, grittiness/dryness, itching, photophobia, swelling/tenderness)	
10	Explore visual disturbance (if relevant): affected eye(s), onset, continuous or intermittent, severity, exacerbating factors, relieving factors, distance and/or near vision affected, central or peripheral visual field affected, double vision, positive visual symptoms, visual distortions)	
11	Explore eye pain (if relevant): use SOCRATES	
12	Explore eye trauma (if relevant): mechanism (e.g. chemical, blunt, sharp), size, speed, nature of flying object	
13	Explore the patient's ideas, concerns and expectations	
14	Summarise the patient's presenting complaint	
Systemic enquiry		
15	Screen for relevant symptoms in other body systems	
Past ocular history		
16	Previous similar episodes	
17	Previous eye problems/diagnoses	
18	History of eye trauma	
19	History of ocular surgery	
20	Use of prescription glasses or contact lenses	
Past medical history		
21	Screen for conditions that can be associated with ophthalmic disease (e.g. diabetes, hypertension, autoimmune disease)	
22	Ask about other medical diagnoses and previous surgical history	
23	Ask if the patient has any allergies and if so, clarify what kind of reaction they had to the substance	

Drug history		
24	Ask if the patient is currently taking any prescribed medications or over-the-counter remedies (including eye drops)	
Family history		
25	Ask the patient if there is any family history of similar complaints or diagnosis of eye disease	
26	Ask if there is any family history of hypertension, diabetes or rheumatological disease	
Social history		
27	Explore the patient's general social context (accommodation, who the patient lives with, how the patient manages with activities of daily living, care needs)	
28	Take a smoking history	
29	Take an alcohol history	
30	Ask about recreational drug use	
31	Ask about the patient's occupation	
32	Ask if the patient drives	
Closing the consultation		
33	Summarise the salient points of the history back to the patient and ask if they feel that you've missed anything	
34	Thank the patient for their time	
35	Dispose of PPE appropriately and wash your hands	
Key communication skills		
36	Active listening	
37	Summarising	
38	Signposting	