OSCE Checklist: Cough 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 if the patient can localise the cough (e.g. upper throat vs chest)	
8	Onset: clarify when the cough first started and if it came on suddenly or gradually	
9	Character: ask the patient to describe the cough (productive vs dry) and specifically ask about haemoptysis	
10	Associated symptoms: ask if there are any other associated symptoms	
11	Time course: ask how the cough has changed over time (e.g. presence of diurnal variation)	
12	Exacerbating or relieving factors: identify any triggers for the cough (e.g. position or environment) and ask if anything makes it worse or better	
13	Identify any red flags for lung cancer (e.g. unexplained haemoptysis, weight loss, fatigue)	
14	Explore the patient's ideas, concerns and expectations	
15	Summarise the patient's presenting complaint	
Systemic enquiry		
16	Screen for relevant symptoms in other body systems	
Past medical history		
17	Screen for conditions that may be associated with cough (e.g. asthma)	
18	Ask about other medical diagnoses and previous surgical history	
19	Ask if the patient has any allergies and if so, clarify what kind of reaction they had to the substance	
Drug history		
20	Ask if the patient is currently taking any prescribed medications or over-the-counter remedies	
21	Ask if the patient if they're experiencing any side effects from their medication	
Family history		
22	Ask if there is any family history of respiratory disease	

Social history		
23	Explore the patient's general social context (accommodation, who the patient lives with, how the patient manages with activities of daily living, care needs)	
24	Take a smoking history	
25	Take an alcohol history	
26	Ask about recreational drug use	
27	Ask about the patient's occupation (current and previous) and identify any relevant exposures to asbestos, allergens or infections	
Travel history		
28	If the patient's symptoms suggest an infective aetiology, particularly tuberculosis (TB), take a travel history to assess exposure risk	
Closing the consultation		
29	Summarise the salient points of the history back to the patient and ask if they feel that you've missed anything	
30	Thank the patient for their time	
31	Dispose of PPE appropriately and wash your hands	
Key communication skills		
32	Active listening	
33	Summarising	
34	Signposting	