OSCE Checklist: Fall 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	Clarify when the fall occurred	
8	Ask about events before the fall: activities, warning signs and physical symptoms (e.g. dizziness, palpitations)	
9	Ask about the nature of the fall and how the patient landed	
10	Ask about loss of consciousness and the patient's recollection of the fall	
11	Ask about events after the fall: duration on the ground, if they needed assistance to get up, symptoms after the fall	
12	Ask how the patient feels now and identify symptoms which may suggest injuries	
13	Explore how the fall has affected the patient (e.g. fear of falling again)	
14	Identify risk factors for future falls	
15	Explore history of previous falls (if relevant)	
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 and identify any preceding illnesses	
Past medical history		
19	Screen for conditions which increase the risk of falls (e.g. Parkinson's disease)	
20	Ask about other medical diagnoses and previous surgical history	
21	Ask if the patient has any allergies and if so, clarify what kind of reaction they had to the substance	
Drug history		
22	Ask if the patient is currently taking any prescribed medications or over-the-counter remedies	
23	Ask if the patient if they're experiencing any side effects from their medication	
24	Identify high risk medications for falls (e.g. anticholinergics, multiple antihypertensives)	

Family history		
25	Ask if there is any relevant family history	
Social history		
26	Explore the patient's general social context (accommodation, who the patient lives with, how the patient manages with activities of daily living, care needs)	
27	Identify any hazards at home or safeguarding concerns	
28	Take a smoking history	
29	Take an alcohol history	
30	Ask about fluid intake	
Closing the consultation		
31	Summarise the salient points of the history back to the patient and ask if they feel that you've missed anything	
32	Thank the patient for their time	
33	Dispose of PPE appropriately and wash your hands	
Key communication skills		
34	Active listening	
35	Summarising	
36	Signposting	