OSCE Checklist | Abdominal Pain 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 where the abdominal pain is	
8	Onset: clarify when the pain first started and if it the onset was sudden or gradual	
9	Character: ask the patient to describe how the abdominal pain feels	
10	Radiation: ask if the pain moves anywhere else	
11	Associated symptoms: ask if there are any other associated symptoms (e.g. gastrointestinal symptoms, urological symptoms, gynaecological symptoms)	
12	Time course: clarify the time course of the pain and whether it occurs in discrete episodes or is continuous	
13	Exacerbating or relieving factors: ask if anything makes the pain worse or better and any identify any triggers	
14	Severity: ask how severe the pain is on a scale of 0-10	
15	Explore the patient's ideas, concerns and expectations	
16	Summarise the patient's presenting complaint	
Systemic enquiry		
17	Screen for relevant symptoms in other body systems	
Past medical history		
18	Screen for conditions that increase the risk of gastrointestinal disease	
19	Ask about pre-existing gastrointestinal disease	
20	Ask about other medical diagnoses, previous surgical history and procedures	
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	

Family history		
23	Ask if there is any family history of gastrointestinal disease	
Social history		
24	Explore the patient's general social context (accommodation, who the patient lives with, how the patient manages with activities of daily living, care needs)	
25	Take a smoking history	
26	Take an alcohol history	
27	Ask about recreational drug use	
28	Ask about diet	
29	If indicated, ask about sexual history	
Closing the consultation		
30	Summarise the salient points of the history back to the patient and ask if they feel anything has been missed	
31	Thank the patient for their time	
32	Dispose of PPE appropriately and wash your hands	
Key communication skills		
33	Active listening	
34	Summarising	
35	Signposting	