

History Taking

Definitions

- **Clinical Reasoning** – Using the results of questions to think about associated problems and body system changes related to patient's complaint(s).

History Taking Mnemonics

- **S** – Signs / symptoms (what you can physically see & what patient states is wrong)
- **A** – Allergies (to foods, medications, substances, chemicals)
- **M** – Medications (current meds a patient is taking including over the counter)
- **P** – Past med, Hx (pertinent past medical history)
- **L** – Last oral intake (food & drinks) could hint to injury or illness
- **E** – Events leading to injury or illness

Pain Mnemonic

- **O** – Onset (when did pain/ illness start)
- **P** – Provoke/Palliation (what simulates pain or makes it better)
- **Q** – Quality (what does pain feel like, sharp, dull, burning, pounding, crushing, etc.)
- **R** – Radiate/Region (where is the pain and does it go anywhere)
- **S** – Severity (Scale 1 – 10, have you had this type of pain before)
- **T** – Time (how long have you felt this way, and when did you start)

Note: With your female patients ask if there is a possibility that they might be pregnant. They most often will say no because they take contraceptives or use condoms. Even with these measures they can still get pregnant. A more appropriate question is; “**Are you or have you currently had sex, or are you sexually active?**”

Never apologize for asking appropriate questions in your assessment.

Physical Exam / Patient Assessment

Definition

- **Inspection** – Visual examination of patient and surroundings.
- **Palpation** – Physically touching the patient and feeling for injuries.
- **Auscultation** – Using a stethoscope to listen to organs and bodily functions.
- **Percussion** – Use of vibrations and sounds to evaluate the presents of air or fluid in body tissues.
- **Tidal volume** – Volume of gases inhaled during 1 normal breath.
- **Ophthalmoscope** – Inspect structures of the eyes.
- **Otoscope** – Used to inspect structures of inner and middle ear.
- Normal body Temp is **98.6 degrees F or 37 degrees C**.
- **Scene Size up** – Observation of surroundings. (environmental, hostile, situations and hazards)
- **BSI** – Body Substance Isolation.
- **Initial assessment** – Recognizing and correcting all life threatening injuries.
- **Focused assessment** – Detailed questioning and physical exam.
- **Ongoing assessment** – Continuous monitoring of patient condition.
- **Cullen's Signs** – Ecchymosis (bruising) in the superior umbilical region (periumbilical) from internal injury.
- **Grey-Turners sign** – Bruising on the flanks of the abdomen (generally appear in 24-48 hrs).

- **Subcutaneous Emphysema** – Air in the subcutaneous area of the skin. Generally on the chest/neck area from a pneumothorax.

Breath Sounds

- **Diminished** – Vesicular sounds difficult or hard to hear because of restricted or null flow in sections of the lungs.
- **Harsh** – Are audible or turbulent air sounds during respirations.
- **Crackles** – AKA Rales – Sounds like fine rubbing like rubbing hair together.
- **Rhonchi** – Low tone rumbling sound.
- **Stridor** – Upper airway narrowing sounds like a high pitched crowing or seal’s bark.
- **Wheezes** – Musical sound on inhalation. Signs of bronchiole constriction.
- **Bruit** – Abnormal murmuring sound. May feel vibrations / rumbling.
- **Vesicular/Eupnea** – Quiet, normal breath sounds.
- **Apnea** – Not breathing or absent of breathing.
- **Biot's** – Cluster respirations with intermittent periods of apnea.
- **Kussmaul** – Abnormally rapid deep sighing typical of DKA or metabolic acidosis.
- **Agonal** – Gasp of air followed by periods of apnea.
- **Eupnea** – Normal breathing.
- **Cheyne–stokes** – Periods of breathing (fairly consistent) then period of apnea possibility from Brain damage / ICP

Physical Exam and Palpation

- **D** – Deformities
- **C** – Contusions
- **A** – Abrasions
- **P** – Punctures
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- **B** – Burns
- **T** – Tenderness
- **L** – Lacerations
- **S** – Swelling

C – Circulation

P – Perfusion

S – Sensation <>

M – Movement

M – Movement

S – Sensation

Primary Assessment

- **A** – Airway
- **B** – Breathing
- **C** – Circulation (check for pulses, central & peripheral)
- **D** – Disability (level of consciousness)
- **E** – Expose/Environment (Expose all potential injuries/possible environmental cause)

Neurological Evaluation

- **A** – Alert
- **V** – Verbal
- **P** – Painful
- **U** – Unresponsive

Pupils

- **P** – Pupils
- **E** – Equal
- **R** – Round
- **R** – Reactive
- **L** – Light (reactive to)

Ambulation & Motor Strength

- **Grips** – Check for equal grips in the hands
- **Push / Pull** – Push and pull on your hands with their feet (is it equal?)

Head Assessment

- **H** – Head
- **E** – Eyes
- **E** – Ears
- **N** – Nose
- **T** – Throat

Skin Signs

- **Flushed** – Capillary dilation that leads to a bright red skin color.
- **Cyanotic** – Bluish color of skin from hypoxia.
- **Ashen** – Grayish white color.
- **Pallor** – Virtually the same as pale.
- **Jaundice** – Yellow color of skin and eyes.
- **Diaphoretic** – Sweaty skin.
- **Pale** – White lifeless color.
- **Temperature** of skin (hot, cool, or room temperature).

Vital Signs

- Airway / breathing (is it adequate and secure)
- Pulse / circulation (pulse rate & quality)
- Capillary refill (is it > or < than 2 sec)
- Skin signs (color and temperature)
- Pupils (equal, round, reactive? or fixed and dilated?)
- Blood pressure (high or low)
- Blood sugar level
- Temperature (body temp is not usually checked in the field)
- LOC (level of consciousness) altered or normal for patient
- Motor tone & ability (ambulation and CSM)
- **Pain** – Does what the patient says match physical manifestations of pain? (use physical characteristics of pain)

Medical Assessment

Determine scene safety
Determine # of patients
Determine a MOI
Additional resources needed?

These flow charts
are examples of
treatment options,
always follow your
local medical
direction, protocols
and standing orders.

Establish level of consciousness.
Assess: airway, breathing
circulation
Control bleeding and or manage all
life threatening injuries

BLS Assessment

Provide O2 therapy
Determine chief complaint
Obtain baseline vitals

Determine if rapid
transport or additional
ALS resources are needed

Ongoing assessment
Detailed/Focused Exam
SAMPLE/OPQRST
Reassess vitals
Provide appropriate treatment
and transport

Notify Medical Command
Reassess every 5min in critical
Reassess every 15mins in non-
critical

Glasgow Coma Scale

Eye Opening

Spontaneous	4
To Loud Voice	3
To Pain	2
None	1

Verbal Response

Oriented	5
Disoriented	4
Inappropriate Words	3
Incomprehensible	2
None	1

Motor Response

Obeys	6
Localizes	5
Withdraws	4
Flexion Posturing	3
Extension Posturing	2
None	1

Clinical Decision Making / Assessment Based Management

Definitions / Summary

- Formulate a plan based on your assessment.
- **Differential Diagnosis** – An alternative possibility or cause that is leading to the patient's condition, based on your assessment.
- Make interventions as needed.
- Revise treatment as needed to fit the patient condition: maintain flexible treatment plan.
- Run reviews and critique.
- **Pattern Recognition** – Identifying characteristics of illness or injury that present the same way every time in a given condition or illness.
- Avoid tunnel vision.
- Don't stereotype patients.
- Bring **ALL** appropriate equipment to the patient.
- Look to find injuries and do a complete evaluation!

Communications / Documentation

Definitions

- **Simplex mode** – Transmits and receives in one direction at a time.
- **Duplex mode** – Can transmit and receive in both directions at the same time.
- **Multiplex mode** – Transmits 2 or more types of information simultaneously.
- **PSAP** – Public Safety Access Point (dispatches appropriate units)
- **FCC** – Federal Communications Commission (regulates transmissions)
- **SOAP** – Subjective, Objective, Assessment, Plan.
- **Narrative** – Written account of patient assessment and care.