# Patient Assessment

## Primary Assessment

- Forming a **General Impression**
- Assessing the patient's mental status(**AVPU** - **A**lert, **V**erbal, **P**ainful, **U**nresponsive)
    - Manually stabilizing the patient's head and neck when appropriate
- Assessing the patient's **Airway**
- Assessing the patient's **Breathing**
- Assessing the patient's **Circulation**
- Determining the patient's **Priority**

## Secondary Assessment of the Trauma Patient

**Trauma Patient with No Significant Mechanism or Injury**

- Determine the **Chief Complaint**
- Conduct a **History of Present Illness(HPI)**
- Perform a **Physical Exam(DCAP-BTLS)** also called **Wounds, Tenderness, and Deformities**
    - **D**eformities
    - **C**ontusions also called Bruises
    - **A**brasions or scrapes
    - **P**unctures and Penetrations
    - **B**urns
    - **T**enderness
    - **L**acerations
    - **S**welling
- Obtain **Baseline Vital Signs**
- Obtain **Past Medical History(PMH)** also called **SAMPLE**
    - **S**igns and **S**ymptoms
    - **A**llergies
    - **M**edications
    - **P**ertinent Past History
    - **L**ast Oral Intake
    - **E**vents leading to the injury or illness
- Apply cervical collar when appropriate

**Trauma Patient with a Significant Mechanism or Injury**

- Continue Manual Stabilization of the Head and Neck
- Consider Requesting Advanced Life Support(ALS) Personnel
- Perform a Rapid Trauma Assessment
    - Quick Head-to-Toe Assessment Using Only Inspection and Palpation
        - **Note:** Not a Detailed Inspection
- Obtain Baseline Vital Signs and Past Medical History
- Apply cervical collar when appropriate
- After you have performed all critical interventions
    - Repeat your primary assessment
- Perform a more focused Physical Exam

# Secondary Assessment of the Medical Patient

**Responsive Medical Patient**

- History of the Present Illness(**OPQRST**)
    - **O**nset
    - **P**rovokes
    - **Q**uality
    - **R**adiation
    - **S**everity
    - **T**ime
- Past Medical History(**SAMPLE**)
    - **S**igns and **S**ymptoms
    - **A**llergies
    - **M**edications
    - **P**ertinent Past History
    - **L**ast Oral Intake
    - **E**vents leading to the injury or illness
- Perform a Physical Exam
    - Focus on Chief Complaint
- Obtain Baseline Vital Signs
- Administer Interventions and Transport the Patient

**Unresponsive Medical Patient**

- Perform a Rapid Physical Exam
    - Neck – Jugular Vein Distention, Medical ID bracelet
    - Chest – Breathing sounds
    - Abdomen – Distention, Firmness, Rigidity
    - Pelvis – Incontinence of urine or feces
    - Extremities – Pulse, motor function, sensation, oxygen saturation
- Obtain Baseline Vital Signs
- Consider ALS Personnel
- Take a History of the Present Illness and a Past Medical History
- Administer Interventions and Transport the Patient

# Reassessment

- Repeat the Primary Assessment
    - Reassess the patient's mental status(**AVPU** - **A**lert, **V**erbal, **P**ainful, **U**nresponsive)
    - Maintain an open Airway
    - Maintain Breathing for rate and quality
    - Reassess the pulse for rate and quality
    - Monitor skin color and temperature
    - Reestablish patient priorities
- Reassess and Record Vital Signs
- Repeat Pertinent Parts of the History and Physical Exam
- Check Interventions

**Reassessment for Stable and Unstable Patients**

- Every 15 mins. for a stable patient.
- Every 5 mins. for a unstable or potentially unstable patient
- Every 5 mins. for child and pediatric whether they are stable or unstable
- Every 5 mins. when in doubt or as frequently as possible