Patient Assessment

Patient Name: Date: Time:

Airway

Breathing

Circulation

Disability

Environment

Focused Exam

- Head/Neck
- Shoulders/Clavicle
- Chest/Sternum
- Abdomen
- Pelvis/Hips
- Legs/Feet
- Arms/Hands
- Back Cervical Thoracic Lumbar Sacrum Coccyx

Get Vitals

- Time
- Level of Responsiveness (AVPU)
- Heart Rate/Rhythm/Quality
- Respiration Rate/Rhythm/Quality
- Skin Color/Temp/Moisture

History

- Chief Complaint
- MOI (Mechanism of Injury)
- **S**ymptoms
  - **O**nset
  - **P**rovoke/Palliate
  - **Q**uality
  - **R**adiate (Leads to where?)
  - **S**everity (1-10)
  - **T**rend (When did it start)
- **A**llergies
- **M**edications
- **P**ertinent History
- **L**ast Intake/Output
- **E**vents Preceding

Cut Here

Cut Here

SOAP Note

Date: Time:

Patient

Name: Age:

Address: M or F

Phone: Notify:

Relation: Phone:

Subjective

(moi c/c opqrst)

Objective

(Patient Exam SAMPLE History)

Vital Signs

Time	AVPU	HR/Character	RR/Character	SCTM

Assessment

Plan