

APPENDIX: X

TITLE: STANDARDIZED PHYSICAL EXAM AND HISTORY

REVISED: September 28, 2010

General Comment: In pursuit of consistency at the highest level of pre-hospital care, a standardized protocol has been developed to assist field personnel in the completion of a physical exam and history. This protocol established minimum guidelines, while also encouraging field personnel to conduct or obtain a more detailed physical exam or history as required by the specific needs of an injury or illness. Because of circumstances beyond field personnel control, it may not be possible to complete a minimum physical exam or collect history with every patient contact (e.g. safety of scene, pt compliance, environmental hazards, etc.). Reasons that a physical exam could not be completed nor a history collected must be documented.

<u>Physical Exam (with some evaluations):</u>	<u>Location in ESO</u>
Airway	
Patent?	
Self-Maintained?	
Compromise (blood, trauma, emesis, secretions)	Assessment - HEENT
Breathing	
Rate and quality	Vitals
Lung sounds	Assessment - Chest
Word per sentence?	Narrative
Accessory muscle use	Assessment - Chest
Cough	Assessment - Chest
Circulation	
Present/quality/symmetry of pulses	Vitals
Blood pressure (first is manual)	Vitals
Stable vs. Unstable (must have multiple)	Vitals
Deformity	
Deficit	
Existing vs. new	Assessment
Traumatic vs. spontaneous	Assessment
Gross neurological exam	
Facial symmetry, Extremity, Pupil Exam, Speech quality	Assessment
Responsiveness (AVPU, GCS, CAO)	Vitals
Expose	
PRN based on severity of pt injury/illness and current environment.	Assessment
Skin	
Temperature, color, condition	Assessment - Skin
Temperature	
Oral, tympanic, axillary, rectal	Vitals
Appearance	
How found?	Narrative
Environment	
Description of residence or location	Narrative

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<u>History:</u>		<u>Location in ESO</u>
Chief Complaint	<p>Not to be confused with reason for dispatch Not to be confused with field diagnosis (e.g. dispatched for SOB. Pt complains of chest pressure. Field diagnosis: MI)</p> <p>Clinical Impression Field and Narrative</p> <p>Chief complaint belongs to the pt. It can be revealing so don't leave it out even though it might not make sense given the pt's diagnosis.</p>	
Hx Present Illness	<p>Most easily obtained through use of open ended questions</p> <p>OPQRST (or similar). Adults don't get this. Translate. Pt may be poor source of information. Nursing notes or staff report</p>	Narrative
Medications	<p>Pt report</p> <p>Pt list and verify vs. found medications MD on bottle? Compliance? Recently prescribed or new dosing?</p>	<p>Pt Information Tab</p> <p>Narrative</p> <p>Narrative</p>
Allergies	<p>Pt report</p> <p>Pt paperwork</p>	Pt Information Tab
Medical Hx	<p>Pt report</p> <p>Prompts as some pts need to hear examples out loud</p> <p>Paperwork</p> <p>Staff report</p> <p>Dates of events? Surgeries? Dates?</p>	Pt Information Tab
Social Hx	<p>Tobacco/Alcohol/Illicit Drug Use</p> <p>Type? Frequency?</p> <p>Audience vs. the information that is desired</p>	Pt information Tab
Recent trauma/illness	Especially related to current complaint	Narrative
MD List	<p>Medication bottles</p> <p>Pt paperwork</p>	Narrative
Patient Safety	Asked delicately and being mindful of audience	Narrative

History:

Access to
Medical Care

PMD?
Is 911 front-line care?

Location in ESO

Narrative

Code Status

Review of acceptable forms in SWOs
Discuss importance with staff or family

Pt information Tab

Review of Systems Questioning Examples
(Subjective Information)

Constitution	Fatigue, Weight loss/gain, Appetite
Eyes	Vision changes, photophobia, pain
Ears, nose, mouth	HA, tinnitus, vertigo, sore, tooth ache, hoarse, discharge
Respiratory	SOB, sputum production, wheezing, pain with resp., cough
Cardiovascular	Chest pain, edema, dizzy, etc.
Gastrointestinal	Bleeding, eating, nausea, reflux, stool, pain, emesis
Genitourinal	Frequency and quality of urination, blood, odor, appearance, pain LMP _____ G _____ P _____
Musculoskeletal	Aches, joint pain, strength, trauma, fx, swelling
Skin	Changes, rashes, sensitivity
Neurological	Sensation, symmetry, quality of speech, other deficits
Mental state	Manner of interaction, reasonable, scared.

Information gathered from a review of systems should be documented in the **Narrative** portion of the chart.

Standardization of Narrative

The following summarizes the information designated for inclusion into the Narrative portion of ESO.

Reason for dispatch
Pt appearance
Environment
Chief complaint
HPI
Improved limb lead description (if desired)
Compliance with meds or new dosing (if relevant)
Recent trauma/illness (if relevant)
MD List

Standardized Physical Exam & History

Pt safety (if relevant)
Access to medical care (if relevant)
Information generated from a review of systems
How pt moved
Hospital destination (a necessary repeat)
Pt improvement/deterioration
Anything not otherwise documented that is pertinent

It is no longer necessary to revisit a list of treatments in the Narrative portion of ESO. Further, it is generally not necessary to document negative findings.

Physician Pearls:

“No abnormality” can only be documented if all the areas of a standardized physical exam, or a more detailed exam that is injury/illness specific, have been completed and nothing abnormal identified. This assumes that the Paramedic is able to identify grossly abnormal conditions at the examined body locations or reviewed systems.

“No abnormality” may be a relative term. The pt may have an abnormal condition that is normal for them. The finding should be documented as an abnormality (a finding) with reference to onset or the pt’s description of the finding as pre-existing or “normal”.

The physical examination pick lists offered in the current web-based documentation program may be utilized, however that list supplements the areas of exam found in the standardized physical exam/history.