

GENERAL PATIENT ASSESSMENT

1. Initial Assessment
 - A. Scene size up: How many patients are there? What additional resources are necessary? Is the scene safe? Should spinal precautions be taken?
 - B. Rescuer safety: What personal protective equipment should be worn?
 - C. Level of conscious: alert, responds to voice, responds to pain, unresponsive (AVPU)
 - D. Airway: assess for patency, and partial or complete obstruction
 - E. Breathing: assess rate, depth, chest rise, equality
 - F. Circulation: assess pulses (rate, regularity, quality), skin color, capillary refill, obvious bleeding
 - G. Disability: pupils, posturing, seizures, Glasgow Coma Scale
 - H. Expose: as indicated to look for life threatening injuries/conditions
 - I. Vitals: blood pressure, pulse, respirations, skin/body temp, oximetry
2. Focused Assessment: assess areas for pain, tenderness, swelling, bruising, deformity, wounds, and
 - A. Head: blood/fluid from ears, nose, mouth or eyes, pupils
 - B. Neck: jugular vein distention, step-offs, tracheal position, subcutaneous air
 - C. Chest: crepitus, lung sounds, subcutaneous air, paradoxical movement
 - D. Abdomen: rigidity, guarding, rebound tenderness, distention
 - E. Pelvis/Genitals: stability, crepitus, priapism, bleeding
 - F. Extremities: CMS, grip and foot strength, range of motion, pulse equality, edema
 - G. Back: edema
3. Mechanism of injury:
 - A. For MVAs: speed, vehicle damage/intrusion, type of accident, use of seatbelts, airbag deployment
 - B. GSWs/stabbings/assaults: type and/or caliber of weapon, length of knife
 - C. Falls: height, surface landed on
 - D. Sports: helmet or safety equipment worn
 - E. All: potential for head or spinal trauma, determine whether there was loss of consciousness, use of mind altering substances
4. Mechanism of illness:
 - A. When did symptoms begin? Has it changed?
 - B. Does anything make the symptoms better or worse?
 - C. Any previous similar episodes?
 - D. Has there been any loss of consciousness?
 - E. What do the symptoms feel like? (quality, radiation, severity)
 - F. Potential for associated trauma and need to take spinal precautions
 - G. Use of mind altering substances
 - H. Last meal
5. Past Medical History
 - A. Medical conditions/surgeries:
 - B. Medications: dosages, when last taken (if possible, bring medications to hospital)
 - C. Allergies: medications (foods, animals, other as appropriate)
6. Reassessment
 - A. Repeat vital assessment
 1. Minimally every 10 – 15 minutes
 2. Every five minutes if unstable or abnormal
 3. After each procedure or medication administration
 - B. Repeat initial assessment any time patient condition deteriorates
7. ALS Assessment (Electronic Medical Records)
 - A. An ALS assessment must consist of the following components:
 1. Evaluation of ABCs
 2. Assessing for the need of an advanced airway
 3. Auscultation of lung sounds
 4. Assessing for the need of an IV/IO
 5. Assessing for the need of a cardiac monitor
 6. Assessing the need for pain medication
 7. Assuring that BLS skills have been completed