Patient Assessment

- Patient assessment is made up of two parts
  - History
  - Physical Exam
Patient assessment

- In medical cases obtaining an adequate history is as important as, maybe even more important than the physical exam.

- The ability to elicit a good history is the foundation for providing good care.

- Good communication is key!! Ask open ended questions.
Patient assessment

- Listening is an important part of the interview.

- If you listen to the patient, they will tell you what is wrong.

- To be a skilled clinician you must be a good listener.
Patient history

- There are several components to a comprehensive history. This should be done in a systematic order.

- In practice you should be flexible and select components that apply to your patients' situation and status.
Chief Complaint

- Defined as the pain, discomfort or dysfunction that caused your patient to request help.

- Ask open ended questions.

- Report and record patients chief complaint in their own words.
Present Illness

- The chief complaint needs to be explored in greater detail.
- A practical template for exploring the events is the mnemonic:
  - OPQRST-ASPN
Present Illness

- O  Onset
- P  Provocation/Palliation
- Q  Quality
- R  Region/Radiation
- S  Severity
- T  Time
- AS  Associated symptoms
- PN  Pertinent Negatives
Onset

- Gradual or sudden

- What was patient doing when symptoms began.
Provocation/Palliation

- What provokes symptoms (makes worse)
- Does anything palliate symptom (make better)
quality

- How does the patient perceive pain or discomfort.

- Does patient call pain crushing, tearing, crampy, dull, sharp etc...

- Quote patients description in report.
Region/Radiation

- Where is the symptom?
- Does it move anywhere else?
- Determine if actual pain or is it tenderness (pain upon palpation)
- Note any pain that may be referred.
Severity

- How bad is the Symptom
- The pain scale is very important 0-10.
Time

- When did symptoms begin?
- Is it constant or intermittent?
- How long does it last?
- How long has it affected your patient?
- When did previous episodes occur?
- How is it the same/ how is it different
Associated symptoms

- What other symptoms commonly associated with the chief complaint can help you make diagnosis. Ex. Short of breath, nausea, with someone having chest pain.
Pertinent Negatives

- Are any likely associated symptoms absent?
- Absence is as important as Presence.
- Note any element of the history or physical that does not support a suspected diagnosis.
Past Medical History

- The past history may provide significant insights into your patient's chief complaint and your diagnosis.
- Some of the important things we need to know are:
  - Adult diseases, recent accidents or injuries,
  - Surgeries, hospitalizations.
Current Health Status

- Current health status assembles all the factors in your patients present medical condition. Some of the important information is as follows:
  - current meds
  - allergies
  - alcohol, tobacco, drug use
  - diet
Current health status

- Immunizations
- Sleep patterns
- Exercise and leisure activities
- Environmental hazards
- Family history
- Home situation
- Daily life
Core Questions to ask

- The are 10 core questions that should be included on any medical history form.

1. Are you under a physicians care or have you been during the past 5 years, including hospitalization, and surgery.

- Many problems may be identified if this question is worded correctly and properly followed up.
Core Questions

2. Are you currently under a doctor's orders or taking any medications, including birth control pills, over the counter drugs, herbal supplements, homeopathic preparations.

This question elicits more information about the severity of the patient's problems than any other part of the medical history.
Core questions

- 3. Do you any allergies or are you sensitive to any drugs or substances?

  - Specifically ask about penicillin, novocaine, aspirin, latex, or codeine.
4. Have you ever bled excessively after a cut, wound or surgery? Have you ever received a blood transfusion.

Serious bleeding problems usually require treatment that the patient recalls.
Core Questions

5. Are you subject to fainting, dizziness, nervous disorders, seizures or epilepsy?

- This question may uncover patients who
- ‘pass out’ at sight of syringe or blood.
- meniere syndrome
- psychiatric illness
- seizures
Core Questions

- 6. Have you ever had any difficulty breathing? This includes asthma, emphysema, chronic cough, pneumonia, Tuberculosis, or any other lung disorder?
- Do you use any tobacco products?
- Do you snore or have been diagnosed with sleep apnea.
Core Questions

7. Have you or your family members ever had any anesthesia–related problems.

This question may help identify difficult airways, or patients at risk for MH.
Core Questions

- 8. Do you have heart disease or a history of chest pain or palpitations?
- You may want to include dizziness with exertion, syncope during or following exertion.
Core questions

9. If your staff is asking these questions, they should include the following

“Is there anything you would like to discuss alone with the Doctor”. 
Core questions

10. Do you currently use or have a history of using recreational drugs.

-Hopefully this will illicit an honest answer.
Additional questions

- When anesthesia is going to be given, it is important to ask when the patient ate, or last drank fluids.

- The presence of a responsible party to transport the patient home.

- With females ask about pregnancy.
Review of Symptoms

- The review of symptoms is a series of questions designed to identify problems your patient has not mentioned.

- It is a system-by-system list of questions that are more specific than those asked during the basic history.
What is patients usual weight, have their been any changes? Has there been any weakness, fatigue, or fever.
Skin

- Is there any rashes, lumps, sores, itching, dryness, color changes.
HEENT

- Head, Eyes, Ears, Nose and throat.
- Does the patient have any headaches, any nausea, recent head trauma, vertigo.
- Any blurred vision, spots, flashing lights,
- Sore throat, difficulty swallowing
Respiratory

- Does patient have any wheezing, coughing up blood, asthma, COPD, Pneumonia,
Cardiac

- Heart Problems
- hypertension
- MI
- Palpitation
- Dyspnea
G.I.

- Nausea, vomiting
- Bloody, tarry stools
- Abdominal pain
neurologic

- History of fainting, blackouts, seizures, speech difficulty, vertigo, weakness, paralysis.
Endocrine

- History of thyroid problem
- Excessive sweating
- Cold intolerance
- History of diabetes
- Excessive thirst, hunger, urge to urinate
Physical Exam

- Actually begins when you first set your eyes on the patient.
- You can immediately assess the following:
  - General appearance
  - Level of consciousness
  - Breathing effort
  - Skin color
  - Skin temperature
Appearance

- Look good vs Look bad
- Level of consciousness
- Signs of distress
- Skin color
- Posture, gait
- Dress, grooming, hygiene
- Odors
- Facial expression
Vital Signs

- Pulse
- Respirations
- Blood Pressure
- Temperature
- Pulse oximetry
- Capnography
- Cardiac monitoring
- Blood glucose
Examination Techniques

- There are four techniques of the physical exam.
  - Inspection
  - Palpation
  - Percussion
  - Auscultation
Inspection

- The process of informed observation.
- A simple non-invasive technique often taken for granted.
- One of the most valuable ways to assess.
Palpation

- Using your sense of touch to gather information.
Auscultation

- Listening with a stethoscope to chest, abdomen.

- Difficult to master.
Percussion

- NOT Reliable
Summary of Data Required in the Office Record.

- A written signed and dated medical history containing the vital statistics and core medical information.

- An exam chart with the proposed procedures clearly indicated and the probable complications written on the record.
Summary of Data required in the office record

- ASA physical status
- Consent forms
- If indicated appropriately labeled x-rays
- Anesthesia record should document the patients status at time of discharge. (Aldrete scale)
Summary of data required in the office record

- A time oriented anesthesia record indicating anesthetic agent used, amounts, times given, and if O2 was administered.

- Preoperative, postoperative, and discharge vitals should be recorded.

- Any unusual reaction/complication needs to be documented.
Summary of Data Required in the office record

- A record of prescriptions given. A duplicate copy of the prescription is preferred because it gives complete data on dosages, instructions for taking the meds, and the total amount of the medications prescribed.

- ***You must have good documentation***
We must remember the Six Rs
- Read the scene
- Read the patient
- React
- Reevaluate
- Revise the management
- Review your performance
Read the scene

- Evaluate why patient is having a problem
Read the patient

- Identify life threats
- Observe patient (LOC, color, C/C
- Vital signs
React

- Treat life threatening problems
- Determine other serious conditions
Re evaluate

- Conduct a focused and detailed physical assessment.
- Note response to interventions.
Revise management plan

- Change or stop interventions that are not working, making condition worse.
Review

- Review your performance of yourself and staff.
- Be honest
- Look for better ways to handle emergency
- CISM
Clinical decision making is essential when an emergency arises in the office.

Your ability to gather information, analyze it, and make a critical decision on treatment, may make the difference between life and death.