Chapter 11: Focused History and Physical Examination of Medical Patients

Case History
On arrival at a nursing home, you find an alert, 65-year-old male complaining of chest pain and shortness of breath that has been present for 5 hours. The staff informs you that this patient arrived today and they do not have any information about him.

Scope of History
- History is key to assessment of the medical patient.
  - Points to areas of the body that require physical examination
  - Provides clues to preexisting conditions
- Patients with no prior history of medical problems need to have their condition explored to identify the underlying problem.
Scope of History

- Patients with known history may be aware of the probable cause of their condition.
  - Examples
    - Asthma
    - Heart disease
    - COPD
- The extent of history and scope of the physical exam will vary among patients.

Responsive Patients

- Sequence for responsive patients
  - Obtain the SAMPLE history.
  - Perform a physical examination focused on chief complaint.
  - Obtain baseline vital signs.

Unresponsive Patients

- Rapidly assess all body regions.
- Obtain baseline vital signs.
- Obtain SAMPLE history from family or bystanders.
Chief Complaint

- Expression of the patient's main problem in his own words
  - "I feel terrible chest pain."
  - "I feel short of breath."
  - "I have a severe pain in my abdomen."

Assess History of Present Illness

- Expands on the chief complaint
- Systematic questions
- O-P-Q-R-S-T approach

Assess SAMPLE History

- Signs and symptoms
- Allergies
- Medications
- Past medical history
- Last oral intake
- Events leading up to incident
Symptoms — Questions About the History of Present Illness

- Onset
- Provocation
- Quality
- Radiation
- Severity
- Time

Assess Complaints

Onset

- Ask the patient to describe when the complaint first occurred.
- What was the patient’s activity at the time of onset?
  - Running, walking, sitting, driving, etc.
- In which order did signs and symptoms appear?
  - “I have been short of breath for 2 hours.”
  - “I developed chest pain and nausea 30 minutes ago.”

Assess Complaints

Provocation

- What makes the symptoms worse?
- What makes the symptoms better?

Examples
  - “The pain increases when I walk.”
  - “My abdominal pain decreased after I took an antacid.”
  - “Lying flat makes my breathing worse.”
  - It is easier to breathe when I sit up.”
Assess Complaints

Quality

- Description of symptoms in patient’s own words

- Examples
  - “The chest pain feels like someone is sitting on my chest.”
  - “It feels like a sharp, stabbing pain in my lower abdomen.”
  - “It feels like a tearing sensation in my chest and back.”

Assess Complaints

Radiation

- Pain may spread from one area to another.

- Ask the patient whether the pain travels.

- Examples
  - Heart attack pain may travel to the arms, neck or jaw
  - Spleen injuries may cause pain in the shoulder
  - Appendicitis may cause pain around the umbilicus (belly button).

Assess Complaints

Severity

- Ask the patient to describe severity of pain on a scale of 1 to 10.
  - 10 being the worst
  - 1 being the least

- During reassessment, have the patient rate the pain again.
  - This can show trends in relation to treatment (e.g., oxygen).
Assess Complaints

**Time**

- Duration of significant signs and symptoms

- Examples
  - “I have had the pain for the past 2 hours.”
  - “My breathing has been getting worse over the past hour.”

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SAMPLE History

**Allergies**

- Ask patients if they have any allergies.
  - Examples
    - Foods
    - Medications
    - Bee stings

- Allergy history is critical to identifying possible causes since treatments may cause allergic reaction.

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SAMPLE History

**Medications**

- Medications may provide a clue to the cause of the condition.

- Medications may be the cause of the condition.

- Medications may alter vital signs and may confuse assessment.
  - Drugs may lower blood pressure or slow pulse rate.
SAMPLE History
Past Medical History

- May provide valuable clues to the underlying condition
- In adults, always ask about
  - High blood pressure
  - Heart disease
  - Diabetes
  - Chronic obstructive pulmonary disease (COPD)

SAMPLE History
Last Oral Intake

- When did the patient last eat?
  - Particularly important for patients with diabetes
- When did the patient last drink?
- Also note compliance (or lack of compliance) in taking prescribed medications.

SAMPLE History
Events Leading to Present Illness

- Ascertained the chronology of events leading to the call for help.
- Determine whether the patient has had any recent trauma.
  - Example
    - A patient found unresponsive may have experienced head injury days or months before.
Unresponsive Medical Patients

Unresponsive medical patients or patients with altered mental status require a rapid assessment similar to a rapid trauma assessment to ensure trauma is not playing an underlying role.

Rapid Assessment

- **Head**
  - DCAP-BTLS
  - Crepitation
  - Careful palpation to avoid injury to brain

Rapid Assessment

- **Neck**
  - DCAP-BTLS
  - Crepitation
  - Subcutaneous emphysema
  - Jugular venous distention
  - Tracheal shift
Rapid Assessment

- Chest
  - DCAP-BTLS
  - Breath sounds
  - Paradoxical breathing

Rapid Assessment

- Abdomen
  - DCAP-BTLS
  - Firm vs. soft
  - Distended

Rapid Assessment

- Pelvis
  - DCAP-BTLS
  - Crepitation
  - Tenderness
  - Motion
Rapid Assessment

- Lower Extremities
  - DCAP-BTLS
  - Distal pulse

Rapid Assessment

- Lower Extremities
  - Sensation
  - Motor function

Rapid Assessment

- Upper Extremities
  - DCAP-BTLS
  - Distal pulse
Rapid Assessment

- Upper Extremities
  - Sensation
  - Motor function

Rapid Assessment

- Back
  - DCAP-BTLS
  - Look for exit wounds with penetrating trauma

Unresponsive Medical Patient

- Rapid assessment
- SAMPLE history
- Baseline vital signs
**SAMPLE History**

- Bystander
- Family
- Friends

**Assess Baseline Vital Signs**

- Pulse
- Respiration
- Blood pressure
- Temperature

**Provide Emergency Medical Care**

- Based on signs and symptoms
- In consultation with medical direction
Respecting Privacy and Autonomy

- Be sensitive to a patient’s right to privacy during questioning and physical examination.
- Be sure to tell patient what you are going to do before you do it.
  - Gather cooperation
  - Patient consent

Summary

- History is a key aspect in the assessment of medical patients.
- Responsive patients require a focused examination.
- Unresponsive patients require a rapid assessment.