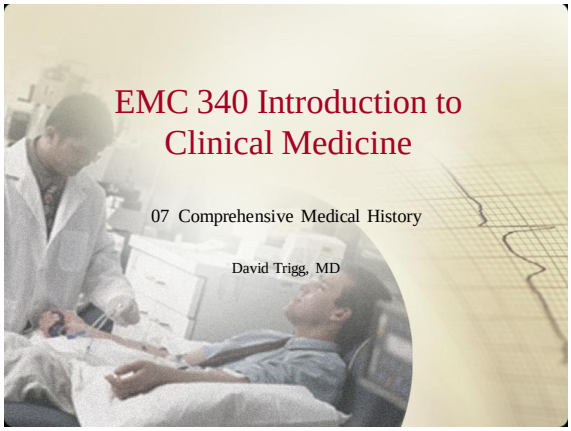

EMC 340 Introduction to Clinical Medicine

07 Comprehensive Medical History

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Outcomes

At the successful completion of this lecture, the learner will:

- Describe the structure and purpose of the Comprehensive Medical History
- Identify appropriate history taking techniques for the non-trauma patient (NSC 3-1)*
- Interpret an array of clinical information and recognize relevant and efficient approaches to assessment and treatment (NSC 7-1)*
- Prioritize clinical assessment and treatment options (NSC 7-1.14)*

*National Standard Curriculum

Outcomes, continued

- Understand how emergency department or paramedic approach must be an appropriate and accurate (sensitive) assessment tool for detecting a potentially life threatening problem.

Primary Stabilization

- Scene Safety / PPE
- C
- A
- B
- C
- D
- E
- VS
- If timing is now appropriate, consider the history

Medical History

- Subjective
- A careful history establishes a foundation for the care of the non-trauma, medical patient.

  ≈ 90% of primary care medical diagnoses are suggested by the history alone

Complete History

A *complete history* goes beyond an "AMPLE" history and also includes:

- chief complaint
- past medical history
- family history
- social and occupational history
- lifestyle, living circumstances, risk factors

Sources of Patient History

Preliminary information that precedes the patient's story is available from:

- dispatch
- bystanders and/or family members
- first responders at the scene

Initial History

- Age
- Sex
- Chief complaint
- Past medical history
- List of medications
- Initial vital signs
- Response to initial treatments

Chief Complaint

- The chief complaint is often the reason EMS was called
- Document in the patient's own words
- For the unconscious patient, make observations of probable presenting reasons for dispatch

The Present Illness

- An elaboration of the chief complaint
- Attributes of symptoms will help define the present illness
- Use mnemonic OPQRST - ASPN

O P Q R S T

- **O**nset - When did the problem begin?
- **P**rovocation or Palpation-precipitating or alleviating factors
- **Q**uality-sharp, crushing, tearing, cramping?
- **R**egion and **R**adiation-where's the symptom and does it move from the source
- **S**everity – 0-10
- **T**iming how long has symptom lasted? Constant? Interval or frequency?

A S P N

- **A**ssociated **S**ymptoms
  - Additional symptoms that are associated with the chief complaint.
- **P**ertinent **N**egatives
  - What pertinent associated symptoms are absent?

Past Medical History (PMH)

- The chief complaint can be explained largely by a positive PMH.
- Use the mnemonic A M P L E
  - Allergies
  - Medications
  - Past illness or injury
  - Last meal, the last few days
  - Events surrounding the present illness

Past Significant Illness Or Injury

- Medical
- Surgical
- Obstetric
- Psychiatric
- Infectious

CHILD

- Medical - past and current adult illnesses
- By convention the following are asked:
  - **C**oronary or other heart disease
  - **H**ypertension
  - **I**nfection - HIV, TB
  - **L**ung - COPD, asthma
  - **D**iabetes

Family History

- Surveyed primarily for pertinent positives to the previous illnesses
- In addition, in primary care, it is often very helpful to ask about :
  - History of alcoholism
  - History of mental illness
  - Familial History
    - Siblings and parents only (distant relatives usually not helpful)

Current Health Status

It is also common to survey emergency patients for the following:

- Drug use
  - Tobacco
  - Alcohol
  - Other
- Living situation
- Environmental / occupational hazards

CAGE Survey

CAGE questionnaire- a quick survey for detecting alcoholism

- Have you ever felt the need to **C**ut down on drinking (use of the drug)?
- Have the felt **A**nnoyed when others criticize your drinking?
- Have you ever felt **G**uilty about drinking?
- Have use every use alcohol first thing in the morning as an **E**ye opener or to help you feel better?

Review of Systems

- Should **not** necessarily be tailored to patient's chief complaint (only if time allows)
- Main purpose
  - To avoid missing any important symptoms
  - To detect problems that the patient may have neglected to mention

Review of Systems

- Fairly general questions can be asked about each major body system
- Important to for the ambulatory care paramedic to become familiar with these questions
- Some clinicians combine the ROS with the physical exam, asking about each system quickly while performing physical exam (inefficient for the patient with multiple somatic complaints)

Review of Systems

Sample questions:

- HEENT –"Any trouble with headaches?"
- Respiratory –"Any trouble with your breathing?"
- GI –"Have you vomited or passed any blood?"
- GU – "Any trouble with your urine?"
- Gyn –"When was your last menstrual period?"
- Neuro –"Have the ever had a stroke?"
- Psych –"Have the had depression or an anxiety disorder?"

Review of Systems

- Familiarize yourself with some of the pertinent positives and medical terminology in the R O S :
  - HEENT - *tinnitus* (ringing in ears)
  - Respiratory - *hemoptysis* (blood sputum)
  - CV - *orthopnea* (as SOB while supine)
  - GI - *hematemesis* (vomiting blood)
  - GU - *polyuria* (frequent urination)
    - *nocturia* (excessive nighttime urination)
  - E X T R - *intermittent claudication* (calf pain upon exercise)

Summary

We have discussed :

- Comprehensive Medical History skills needed for emerging roles and responsibilities of paramedics educated in the National Standard Curriculum.
- The structure and purpose of the Comprehensive Medical History.
- Obtaining appropriate history for the non-trauma patient.

Summary, continued

- Interpreting information and recognizing the appropriate approaches to assessment and treatment.
- Prioritizing assessment and treatment options.
  - Paramedic approach must be appropriate and accurate (sensitive) at finding a potentially life threatening problem.