# Patient Assessment

***Establish Control / Assess Scene***

Before moving to a patient's side, pause for a few moments to make sure the scene is safe. Establish body substance isolation (BSI). Determine, if possible, the mechanism of injury (MOI).

Introduce yourself, state your qualifications, and offer to help. Ask what happened.

***Initial Assessment / ABCDE's***

Identify and treat any immediate threats to life.

**A**— Check the patient's Airway. If unresponsive, establish and maintain one.

**B**— Assess Breathing. If none, perform CPR.

**C**— Assess Circulation. Serious bleeding? Stop the leak.

**D**— Assess for Disability. If you suspect a spine injury, take control of the head.

**E**— Assess the threat of the Environment and Expose injuries. Protect from cold. Expose patient's body to assess any suspected injuries.

***Hands-On Physical Exam***

A detailed head-to-toe assessment for additional problems and injuries is needed. Expose suspected injuries underneath clothes to assess properly.

**SAMPLE *History***

- **S**igns (observed) and Symptoms (described by the patient).
- **A**llergies: To what? Medications? Latex? Bee stings? Foods?
- **M**edications: Taking any? For what? Need to take? Indications of substance abuse?
- **P**ertinent medical history?
- **L**ast oral intake: When? What? Alcohol?
- **E**vents leading up to problem. Mechanism of injury? Medical/environmental factors?

***Documentation***

Use the SOAP acronym (Subjective, Objective, Assessment, Plan) to organize your verbal and written documentation of the incident.

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