Taking a Patient History

Determine the reason that the patient has come in to see you. This is the chief complaint.

Do a focused history on the system involved with the chief complaint, bearing in mind that it may involve numerous systems.

Explore the symptoms relative to the chief complaint using the "OPQRSTA" format:

O - Onset of Symptoms (when, what were you doing)

P - Progression of Symptoms

Q - Quality of Symptoms (burning, stabbing, squeezing)

R - Radiation of Symptoms (usually pain)

- Relieving (what do you do to get relief from the symptoms)

S - Severity of Symptoms (try to quantify this, use pain scale or other assessment tools)

T - Timing of the Symptoms (constant, intermittent, sporadic)

A - Associated Symptoms (nausea, vomiting, diarrhea, fever, etc.)

- Aggravating Symptoms (what makes it worse: eating certain foods, position, activity)
- Alleviating (what do you do to get relief from the symptoms)

For Trauma patients attempt to get a "SAMPLE" history:

S - Symptoms

A - Allergies

M - Medications

P - Past Medical History

L - Last Meal

E - Event History