

PATIENT'S NAME \_\_\_\_\_

WE ARE TRANSPORTING A (AGE) \_\_\_\_\_ YEAR OLD (RACE) \_\_\_\_\_ (SEX) M-F

CHIEF COMPLAINT/MECHANISM OF INJURY \_\_\_\_\_

PAST HISTORY \_\_\_\_\_

ALLERGIES \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

LOC ( A-V-P-U) ORIENTED TIMES \_\_\_\_\_ (Person-Place-Time)

PULSE RATE \_\_\_\_\_ QUALITY \_\_\_\_\_ EKG \_\_\_\_\_ B/P \_\_\_\_\_

RESPIRATIONS RATE \_\_\_\_\_ LUNG SOUNDS (L) \_\_\_\_\_ (R) \_\_\_\_\_

OXYGEN SATS \_\_\_\_\_ % PUPILS \_\_\_\_\_ PMS (UPPER) \_\_\_\_\_ (LOWER) \_\_\_\_\_

SKIN (COLOR) \_\_\_\_\_ (TEMP) \_\_\_\_\_ (MOIST) \_\_\_\_\_

OUR PHYSICAL EXAM REVEALS \_\_\_\_\_

TREATMENT (OXYGEN, IV'S, SPLINTS, IMMOBILIZATION, MEDICATIONS, ETC.)

PATIENTS DOCTOR IS \_\_\_\_\_ ETA IS \_\_\_\_\_ MINUTES

**DO YOU HAVE ANY QUESTIONS OR ORDERS?**

<b>S</b> igns/Symptoms	What do you see and hear?
<b>A</b> llergies	Are you allergic to anything?
<b>M</b> edications	Do you take any medications everyday?
<b>P</b> ast History	Has anything like this happened before?
<b>L</b> ast Intake	When did you last eat or drink?
<b>E</b> vents	What were you doing when this started?
<b>O</b> nset	When did this pain start?
<b>P</b> rovocation	Does anything make it better or worse?
<b>Q</b> uality	Can you describe the pain to me?
<b>R</b> elief/radiation	Does it hurt anywhere else?
<b>S</b> everity	Can you rate your pain on a scale of 1-10?
<b>T</b> ime	Have you ever had pain like this before?