EMSTA COLLEGE – EMT PROGRAM

PATIENT ASSESSMENT DOCUMENTATION

(TEN DOCUMENTED PATIENT CONTACTS ARE REQUIRED)

DATE	
STUDENT NAME	
CLASS NUMBER	
AGENCY/FACILITY	

PATIENT ASSESSMENT

AGE	
SEX	
CHIEF COMPLAINT	
STATUS	

ONSET	
PROVOKED	
QUALITY	
REGION / RADIATION	
SEVERITY	
TIME	

VITAL SIGNS

PULSE	
RESPIRATIONS	
BLOOD PRESSURE	
EYES	
LUNG SOUNDS	
LOC	
SKINS	

TREATMENT	

EMT/RN VERIFICATION: _____

ALLERGIES	
MEDICATIONS	
PAST MED. HISTORY	
LAST ORAL INTAKE	
EVENTS LEADING TO	

PHYSICAL EXAMINATION

HEAD	
NECK	
CHEST	
ABD	
PELVIS	
LOWER EXTREMITIES	
UPPER EXTREMITIES	
POSTERIOR	