O – Onset
P – Provocation
Q – Quality
R – Radiate
S – Severity
T – Time

Patient Assessment – Detailed Exam

Karen Owens – **Author** ***Incident Command for EMS (Pennwell Books)***

The acronym O.P.Q.R.S.T. allows us to get more information on the current medical situation are patient is facing. Making sure the questions are pertinent to the chief complaint is important in getting information to assist in patient care. Expanding the questions may also help the patient better understand what you are asking. Asking the right questions can give you a better picture of the problems the patient has and help you create a better treatment plan. Below are some scenarios you can run to practice asking the right questions and getting all possible information.

Questions to Ask

O – When did it start? What were you doing when it started?

P – Is there something you do that makes it worse or better?

Q – Can you describe how your problem feels? Is the pain sharp/dull/constant/intermittent (for pain complaints)? Does it feel like you have a band on your chest or there is tightness in your chest or throat (for breathing difficulty)

R – Can you point with one finger to the center of the pain (if pain)? Does the problem go anywhere else or cause other problems?

S – On a scale of 1-10, with 10 being the worst you've ever felt, how would you rate your problem (pain, difficulty breathing, etc.)?

T – How long has this problem been going on? If it is episodic, how long do the episodes last (important question in potential labor and delivery)?

Practice Scenarios on page 2.

Medical Scenario

46 year old patient states s/he has chest pains

Initial Assessment

A – Airway patent
B – Patient breathing
C – Pulses present, no major bleeds, skin – pale, cool, clammy

OPQRST	SAMPLE
O – 10 minutes prior to calling 911	S – Pain, sweaty, difficulty breathing
P – moving around aggravates the pain	A - none
Q – Crushing, sharp	M - nitro stat
R – Radiates into jaw and left arm	P – heart attack, angina
S – 8	L - dinner
T – Constant – no decrease in pain	E – sitting in chair, watching T.V.

1st Vital Signs	2nd Vital Signs
BP – 110/78	BP – 98/68
Pulse – 100 – Rapid, Strong	Pulse – 100 – Rapid, Strong
Respirations – 14–labored	Respirations – 12 – normal
Pupils – Normal	Pupils – Normal
Skin – Cool, Pale, Dry	Skin – Cool, Normal, Sweaty

Medical Scenario

46 year old patient states s/he has difficulty breathing

Initial Assessment

A – Airway patent
B – Patient breathing
C – Pulses present

OPQRST	SAMPLE
O – 10 minutes prior to calling 911	S – Flushed, Panting
P – No pain, just chest tightness, hard to breathe	A – none
Q – N/A	M - Albuterol
R – None	P – asthma
S – 8	L - Lunch
T – Constant	E – Working out

1st Vital Signs	2nd Vital Signs
BP – 110/78	BP – 98/68
Pulse – 100 – Rapid, Strong	Pulse – 100 – Rapid, Strong
Respirations – 14–labored	Respirations – 12 – normal
Pupils – Normal	Pupils – Normal
Skin – Flushed, Warm, Sweaty	Skin – Flushed, Normal, moist