

NURSING MNEMONICS & TIPS

HEALTH HISTORY
ASSESSMENT"SAMPLE"

	DESCRIPTION	QUESTIONS TO ASK
S	Symptoms <i>Patient's chief complaints</i>	<i>"What's wrong?" "What brought you to the hospital?"</i>
A	Allergies <i>Seeking to know what type of allergic reaction they experience.</i>	<i>"Are you allergic to anything?" "What happens to you when you use something that you're allergic to?"</i>
M	Medications <i>Prescribed, OTC drugs, herbal meds, etc.</i>	<i>"Are you taking any medications?" "What are you taking the medications for?" "When did you last take your medications?"</i>
P	Past Medical Hx <i>Seeking to know the previous state of health, and previous illnesses</i>	<i>"Have you had this problem before?" "Do you have other medical problems?"</i>
L	Last Oral Intake <i>Seeking what are the last oral intakes of the client.</i>	<i>"When did you last eat or drink anything?" "What was it that you last ate?"</i>
E	Events <i>Events leading up to the illness or injury.</i>	<i>Injury: "How did you get hurt?" Illness: "What led to this problem?"</i>

LEARN MORE: **HEALTH HISTORY ASSESSMENT**

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In general, do not obtain a detailed history until life-threatening injuries have been identified and therapy has been initiated. The secondary survey is essentially a head-to-toe assessment of progress, vital signs, etc. SAMPLE is often useful as a mnemonic for remembering key elements of the patient's health history.

Sample Nursing History And Physical

SB Merriam



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