MIRAMAR COLLEGE EMT Program

Patient Assessment Clinical Experience Form

Student's Name_____ **Instructor's Name**_____

Please have your proctor sign and date at the bottom before your shift ends!

Age_____ **year/month/day** **Sex**_____ **Weight** _____**lb/kg**

Chief Complaint _____

History of Event

_____

_____

_____

	Initial	Final
O		
P		
Q		
R		
S		
T		

_____

_____

_____

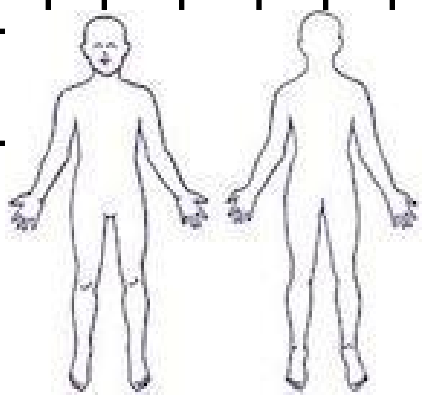
_____

Time	LOC Initial	LOC Final	B/P	Pulse	Resp	Lungs (R)	Lungs (L)	SAT	Color		Temp		Cond		Eyes (R)	Eyes (L)	Blood Sugar
								R/A									
								O2									**Temp**
								Update									

Eyes		**Verbal**		**Motor**	
Spont.	4	Oriented	5	Follows commands	6
Voice	3	Confused	4	Localizes pain	5
Pain	2	Inapp. words	3	Withdraws to pain	4
None	1	Incomp.	2	Flexion	3
		None	1	Extension	2
				None	1

GCS Total:

Secondary Survey



es) (COPD) (psych)

ine) (Splinting)

Proctor Name_____ **Facility**_____

Date_____