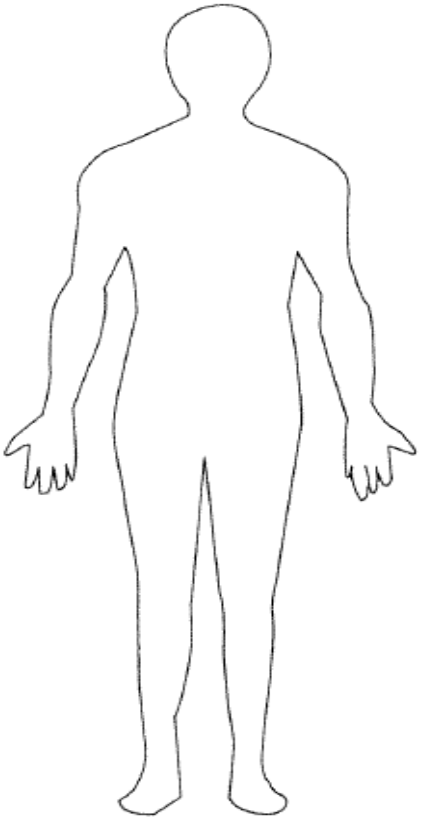
Emergency Medicine Foundations Oral Board Note Sheet

Oral Boards Standard Process:

- **Intro:** "What do I see when I walk in the room?"
- **Vitals:** Ask for full vitals, Ask for Accucheck, Address Pain
- **Primary Survey:** Assess Airway, Breathing and Circulation (Disability/Exposure prn)
- **Sick or Stable:** Decide if patient is currently Sick (intervene immediately) or Stable (collect more history)
- **Initial Action**: as indicated, place 2x LBIV, O2, cardiac monitor, pulse ox, IVF, EKG, procedures prn (Intubate, Needle Thora, Central Line, etc), send Stat Labs and Imaging, Initial Meds (Pain, D50, Blood, etc)
- **HPI:** Obtain HPI from patient +/- family +/- EMS
- **Additional History:** Past Med/Surg Hx, Family Hx, Social Hx (etoh, drugs, smoking), Allergies, Meds, DNR/DNI as needed?, PMD?
- **Physical Exam:** Perform a focused, relevant Physical Exam; do not forget full skin or GU exam as appropriate
- **Repeat Vitals**: ask RN for repeat vitals and reassess patient status
- **Additional Action**: Labs, Imaging, Meds, Procedures prn, Consults prn
- **Ask for Results**
- **Act on Results:** additional testing, meds, consults prn
- **Diagnosis:** Verbalize your working or final diagnosis
- **Update:** Update the patient, family, PMD as needed
- **Disposition** Home, Admit, Transfer

Case #1



HPI

PMHx
PSHx
Allergy
Meds
Fam Hx
Soc Hx
PMD

Orders/Results

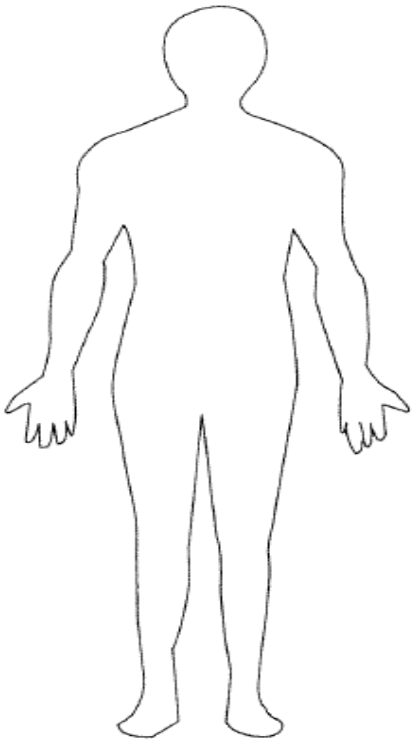
VS BP HR RR Sat Temp FS Preg

Gen
HEENT
Neck
Heart
Lungs
Abd
Rectal
GU
Back
Neuro
Ext
Skin
Lymph
Psych

Action

NOTES:

Case #2



HPI

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Orders/Results

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Action

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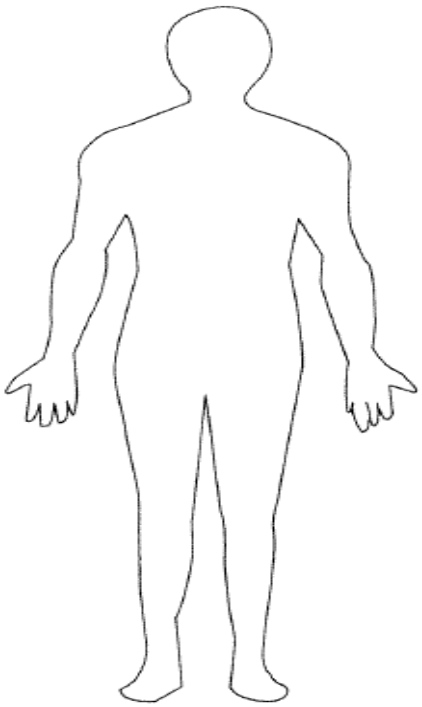
NOTES:

Case #3



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