MODULE 4: SEXUAL HEALTH LESSON 4.8

SAMPLE History

Obj. 4.8: Identify essential subjective information through a SAMPLE history

Label each of the following either Subjective, Objective, Assessment, or Plan.

_________________WT = 210 lbs, HT = 60, BW = 115 lbs, Chol = 255, BP = 140/95

_________________Obese at 183% BMI, hypercholesterolemia, hypertension.

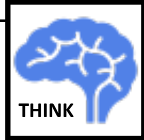
_________________Long Term Goal: Change lifestyle habits to lose at least 70 pounds over a 12 month period. Short Term Goal: Client to begin a 1500 Calorie diet with walking 20 minutes per day. Instructed Pt on lower fat food choices and smaller food portions. Client will keep a daily food and mood record to review next session. Follow-up in one week.

__________________Pt. states that she has always been overweight. She is very frustrated with trying to diet. Her 20-year class reunion is next year and she would like to begin working toward a weight loss goal that is realistic.

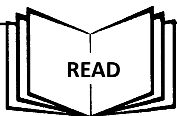
DISCUSS

Compare answers with a partner. Then, together write out a explanation for each of the sections of the SOAP note in the space below. You may refer to your notes from Lesson 1.8 if needed.

SOAP Component	Explanation
Subjective	
Objective	
Assessment	
Plan	

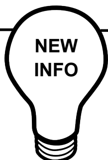


You walk over to your grandmother's house and find her on the ground in the hallway, moaning in pain. You assess the situation and decide that calling 9-1-1 is the best precaution to take. While you are waiting with her for the ambulance, list the questions you would ask her in the space below.



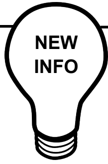
Recall that the Subjective portion of the SOAP note begins with the SAMPLE acronym. Think about the questions you wrote down in the previous exercise. Chances are, many of those questions you would have asked your grandmother would fit into the SAMPLE portion of the Subjective section. But there are certainly many other important questions that you probably did not consider.

The SAMPLE history is a mnemonic tool used in patient assessment. It is often taken at the beginning of the patient's visit, along with vital signs. Emergency medicine health practitioners use the SAMPLE, but it is also used by many other healthcare professionals. A person must be alert to answer the questions for themselves, but in case a person is unable to answer because they are unconscious, incoherent, scared, too young, or for other reasons, the information can be obtained as well as possible from a family member or a friend.



The **SAMPLE** mnemonic stands for:

- **S**ymptoms (and Signs)
- **A**llergies
- **M**edications
- **P**ast medical history
- **L**ast oral intake (and sometimes Last menstrual cycle)
- **E**vents leading to injury or illness



The SAMPLE history may seem like six simple questions, but nothing could be further from the truth. To conduct a complete and comprehensive SAMPLE history, a healthcare practitioner must use far more than six questions. There is no exact set of wording for these questions or order they must come in. It is a skill learned with practice and experience. In the table below, some basic guidance on each part of the SAMPLE will help you get started. After you review the chart, partner up and use the column on the far right as a checklist as you interview your partner about a made-up illness. You each may pick any made-up illness that you know enough about to answer logically.

SAMPLE Component	**Detailed Questions** *(Note: the wording & context should be adapted to be appropriate for the specific situation)*	**PRACTICE:** Partner Interview Checklist
Symptoms (and Signs)	Can you tell me what has been bothering you today? What exactly happened to you *(Once the main symptoms are uncovered, the next step is often more detailed questions about that symptom--think of the FARCOLDER or OPQRST mnemonic. For now, we will skip that part.)*	
Allergies	Have you ever had an allergic reaction? What other things are you allergic to?	
Medications	What medications do you take? Are these all of your medications? Where else do you keep them? (Often useful with the elderly or others who are managing multiple medications) Are you taking all of your medications? How? Are you taking any non-prescription medicine? herbal or alternative medicines? alcohol or drugs?	
Past medical history	What medical conditions do you have? Are there any other medical concerns your doctor has mentioned? What is your family history of illness?	
Last oral intake (& Last menstrual cycle)	When and what was last eaten? How much? How was it cooked/prepared? (Note: A lot can be learned about the patient’s day, general lifestyle, changes in usual routines, appetite, social situation, mood or mental state, and more. Although the exact food they ate may not be relevant, these other things are!)	
Events leading to illness/injury	What happened that caused this event? What was going on prior to this event? Was there an emotional situation that occurred recently for you? (Note: There are many additional questions that can be relevant based on the situation.)	

For each of the following pieces of information, list the SAMPLE category it would most logically fit into.

______________________ 1. "I had a bag of pretzels and a Diet Coke about an hour ago."

______________________ 2. "I got stung by a bee five years ago and broke out in terrible hives."

______________________ 3. "I feel a stabbing pain in my chest & my jaw has been aching for days."

______________________ 4. "I was running in the 800 meter dash and I got dizzy at the finish line."

______________________ 5. "I take one Aspirin per day, along with echinacea and Fish oil tablets."

______________________ 6. "I was diagnosed with Type II diabetes six months ago."

Imagine you are a paramedic called to a scene. Create all the fictional details of the situation by writing a script of the interview with the patient that happens after you arrive. Be sure to include components to clearly and thoroughly cover all aspects of the SAMPLE history.