Clinical Assessment Checklist

First contact and triage

• Identify instability before a comprehensive history: airway, work of breathing, circulation, cognition and major bleeding.

• Measure vital signs when clinically indicated; note temperature, heart rate, respiratory rate, blood pressure, oxygen saturation and pain.

• A patient with ongoing chest pain, severe respiratory distress, new focal neurological symptoms or shock needs emergency assessment, not a routine outpatient workup.

Structured history

• Open with the patient's goals and symptom narrative; clarify onset, duration, course, location, severity, radiation, triggers, relieving factors and associated symptoms.

• Ask about medications including OTC products and supplements, allergies and reaction types, medical and surgical history, family history, occupation and exposures.

• Assess relevant social determinants, sexual and reproductive history when appropriate, substance use and functional effect without assumptions.

Prioritize the problem

• Build a one-sentence problem representation using age context, time course, key syndrome and decisive positives/negatives.

• Separate emergent must-not-miss possibilities from common and probable etiologies.

• Document relevant negatives and uncertainty; do not equate an absent finding with exclusion of disease.

Patient communication

• Use open questions first, then focused questions; request permission before sensitive questions or examinations.

• Use teach-back, interpreters when needed and shared decision-making; document patient preferences and safety net.

Targeted examination

• Select examination maneuvers from the history and acuity, not a generic checklist.

• Recheck abnormal vital signs and compare with the clinical state.

• Explain the examination, obtain consent, preserve privacy and use a chaperone where appropriate.

Core systems

• Cardiorespiratory: heart rate and rhythm, pulses, perfusion, respiratory effort, breath sounds and edema.

• Abdominal: inspection, auscultation as indicated, tenderness, guarding, rebound and masses; avoid delaying emergency assessment for suspected peritonitis.

• Neurologic: mental status, cranial nerves, strength, sensation, coordination, gait if safe and focal asymmetry.

• Musculoskeletal: look, feel, move, function and neurovascular status; test only when safe.

Interpret findings

• Assess diagnostic value using pre-test probability and the reliability of examination findings.

• Normal auscultation does not exclude pulmonary embolism or acute coronary syndrome; a normal single vital sign does not guarantee stability.

• Use calibrated validated instruments and correct cuff sizing for blood pressure.

When to escalate

• Emergent red flags include hypoxemia, confusion, rapidly progressing neurologic deficit, severe dehydration or shock, acute abdomen and threatened limb.

• Document objective findings and communicate urgent referral rationale clearly.

Educational study material only. Follow local protocols and clinical scope of practice; emergency presentations require immediate appropriate evaluation.