Medical Mnemonics Cheat Sheet

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Levels of Response: AVPU scale

A	**Alert**
V	Response to **Verbal Stimuli**
P	Response to **Pain**
U	**Unresponsive**

The AVPU scale measures a patient's responsiveness to indicate their level of consciousness.

Signs vs Symptoms

Signs are commonly distinguished from symptoms and both are something abnormal and relevant to a potential medical condition. A sign is objective and is discovered by the health-care professional during an examination whereas a symptom is subjective, observed and experienced by the patient, and cannot be measured directly.
sIgn: something I can detect even if patient is unconscious.**
sYMptom is something only **hYM** knows about.

Health History Assessment: SAMPLE

S	**Symptoms**
A	**Allergy**
M	**Medications**
P	**Past Medical History**
L	**Last Oral Intake**
E	**Events leading up to** the illness or injury

SAMPLE is often useful as a mnemonic for remembering key elements of the patient's health history.

Eyes Abbreviation

Abbreviations for the eyes are often confusing. OU which stands for the latin term Oculus Uterque means both eyes; OD for Oculus Dexter referring to the right eye and OS for Oculus Sinister for the left eye. Remember the mnemonic above to make sense of these abbreviations.
YOU look with BOTH eyes.
The RIGHT dose won't OD [overdose].
The only one that is LEFT is OS

Rapid Trauma Assessment: DCAP-BTLS

D	**Deformities;** Malformations or distortions of the body.
C	**Contusions;** Injury to tissues with skin discoloration and without breakage of skin; also called a bruise.
A	**Abrasions;** Scrape caused by rubbing from a sharp object resulting in surface denuded of skin.

Rapid Trauma Assessment: DCAP-BTLS (cont)

P	**Punctures or Penetrations;** Wound with relatively small opening compared with the depth; produced by a narrow pointed object
B	**Burns;** Burns are injuries to tissues caused by heat, friction, electricity, radiation, or chemicals.
T	**Tenderness;**The condition of being tender or sore to the touch.
L	**Lacerations;** A torn or jagged wound caused by blunt trauma; incorrectly used when describing a cut.
S	**Swelling;** Sign of inflammation; caused by the exudation of fluid from the capillary vessels into the tissue.

mnemonic to remember specific soft tissue injuries to look for during assessment of a person after a traumatic injury.

Pain Assessment: "OPQRSTUV"

O	**Onset;** When did it begin? How long does it last (duration)? How often does it occur (time)? What were you doing when the pain started?
P	**Provoking or Palliating Factors;** What brings it on? What makes it better? What makes it worse?
Q	**Quality;** What does it feel like? Can you describe it (throbbing, stabbing, dull, etc.)?
R	**Region & Radiation;** Does your pain radiates? Where does it spread? Point to where it hurts the most. Where does your pain go from there?
S	**Severity;** What is the intensity (pain scale of 1-10, visual scales) of the symptom? Right now? At worst? Are there any other symptoms that accompany the pain?
T	**Time & Treatment;** When did the symptoms first begin? What medications are you currently taking for this? How effective are these? Side effects?
U	**Understanding & Impact;** What do you believe is causing this? How is this affecting your ADLs, you and/or your family?

Pain Assessment: "OPQRSTUV" (cont)

V	**Values;** What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom? Do you have any other concerns?

Assessment of pain is a crucial part in the role of nurses, and as such utilizing a problem-solving process becomes part of the equation. Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of damage. Pain is subjective thus a careful assessment and evaluation is needed.

Seven Warning Signs of Cancer: "CAUTION"

C	**Change** in bowel or bladder habits
A	**A sore throat** that does not heal
U	**Unusual** bleeding or discharge
T	**Thickening or lump** in breast or elsewhere
I	**Indigestion or dysphagia**
O	**Obvious change** in wart or mole
N	**Nagging cough** or hoarseness

Early detection is the key in treatment of cancers. The CAUTION mnemonic is used by the American Cancer Society to detect and recognize the early warning signs of cancer. Though one of these signs does not necessarily mean someone has cancer.

Family History Assessment: "BALD CHASM"

B	**Blood pressure;** African Americans have a higher risk for high blood pressure. Poor lifestyle choices and diet, that can be inherited by the family, can also pose as a risk.
A	**Arthritis;** Some types of arthritis run in families. Genes can be a contributing factor that can make someone susceptible to environmental factors that may trigger arthritis.
L	**Lung diseases;** Cystic fibrosis is a common inherited disease that affects mostly the lungs. It is manifested by accumulation of thick, sticky mucous, frequent infections and coughing.
D	**Diabetes;** History of type 2 diabetes in the family poses the patient at increased risk of developing it.
C	**Cancers;** Certain types of cancer, such as breast cancer and colon cancer, appear more frequently in some families.

Family History Assessment: "BALD CHASM" (cont)

H	**Heart diseases;** Genes can pass on the risk of cardiovascular disease, and they can also be responsible for passing on other conditions such as high blood pressure or high cholesterol levels.
A	**Alcoholism;** Certain genetic factors influence alcoholism. Research show that children of alcoholics are about four times more likely than the general population to develop alcohol problems.
S	**Stroke;** Risk for stroke is higher if someone in the patient's direct family line that stroke. Some strokes may be symptoms of genetic disorders like CADASIL.
M	**Mental health disorders;** (depression, bipolar, schizophrenia etc.) Some mental illnesses can run in families, although it may be from variety of factors rather than just genes.

Family history plays a critical role in assessing the risk of inherited medical conditions, chronic illnesses and genetically transmitted diseases. Outline or diagram age and health, or age and cause of death of siblings, parents, and grandparents. Document presence or absence of specific illnesses in family.

Breast Assessment: "LMNOP"

L	**Lump;** Inspect and palpate breast for lumps, masses
M	**Mammary changes;** Inspect and palpate for dimpling, tenderness, abnormal contours
N	**Nipple changes;** Inspect and palpate for nipple retraction, lesions, discharges.
O	**Other symptoms;** Check size, symmetry, appearance of skin, direction of pointing, rashes, and ulceration
P	**Patient risk factors;** Interview patient for predisposing factors, obtain family history or use the Breast Cancer Risk Assessment Tool.

Breast masses show marked variation in etiology, from fibroadenomas to cysts, to abscesses, mastitis, to breast cancer. All breast masses warrant careful evaluation, and definitive diagnostic measures should be pursued.

Alcoholism Screening: CAGE

C	Have you ever felt that you should **CUT** down on your drinking?
A	Have you ever become **ANNOYED** by criticisms of your drinking?
G	Have you ever felt **GUILTY** about your drinking?
E	Have you ever had a morning **EYE OPENER** to get rid of a hangover?

CAGE questionnaire is a widely used and an extensively validated method of screening for alcoholism. Two “yes” responses indicate that the possibility of alcoholism should be investigated further.

Emergency Trauma Assessment: ABCDEFGHI

A	**Airway;** Keep the airway open to allow the body to take in oxygen and expel carbon dioxide. Use the head-tilt chin-lift technique to open the airway. Check or and remove obstructions. A blocked airway can lead to respiratory or cardiac arrest.
B	**Breathing;** Once the airway is open, check for normal breathing, make use of the look, listen, and feel techniques. Look at the chest and observe the rising and falling for normal respiration. Listen for air movement. Feel for air coming through the mouth or nose. If there is no breathing or abnormal breathing, CPR must be initiated with 2 breaths
C	**Circulation;** Oxygen-rich blood cannot be circulated without breathing. Hence, it’s unnecessary to check for pulse to determine whether CPR is needed; commence immediately if no breathing is detected.
D	**Disability;** Check the patient’s neurological status and for obvious deformities or disabilities.
E	**Expose & Examine;** Remove clothing to properly assess patient; be sure to keep the patient warm.
F	**Full set of vital signs;** Note any changes in the following signs: pulse (carotid, brachial, radial), pupils, breathing, level of consciousness, blood pressure, and skin color and temperature.
G	**Give comfort measures;** Continue to rest and reassure. Provide comfort measures and prevent further injury.

Emergency Trauma Assessment: ABCDEFGHI (cont)

H	**History and Head-To-Toe Assessment;** Use the mnemonic SAMPLE to obtain health history and do a head-to-toe assessment after.
I	**Inspect Posterior Surface;** Inspect for wounds, deformities, discolorations, etc.

Mnemonic is used for a quick assessment of trauma patients. This is especially useful for emergency cases. The purpose of primary assessment is to preserve the life of the victim, taking action where needed. Once the victim’s life-threatening conditions have been address, the rescuer must begin secondary assessment.