History of the Present Illness: OPQRST-ASPN-P^{2}N

	Meaning	*Example Questions*	*Clinical Pearls*
O	**Onset**	• What were you doing at the time? • Sudden or gradual?	• Establishing onset clarifies acuity. A sudden onset (e.g., chest pain during exertion) suggests time-critical conditions (MI, stroke, PE). Gradual onset may indicate infection or chronic illness. • Sudden onset pain (especially chest, abdominal, or neuro symptoms) is almost frequently more serious than gradual onset. Think AAA, MI, PE, or stroke.
P	**Provocation / Palliation**	• What makes it worse? • What makes it better? • Effect of rest, activity, or position?	• Helps identify mechanical vs. physiologic causes. Pain that worsens with exertion but improves at rest may suggest cardiac ischemia; pain relieved by position changes may suggest musculoskeletal origin. • Relief with sitting forward = pericarditis; relief with nitro = not always cardiac, can also be esophageal spasm.
Q	**Quality**	• How would you describe it? • Sharp, dull, burning, throbbing, stiffness?	• Symptom descriptors guide differentiation: crushing = cardiac, burning = GI/GERD, tearing = aortic dissection. Capturing the patient's own words avoids bias.
R	**Region / Radiation**	• Where exactly is it—Can you point with one finger? • Does it travel anywhere?	• Localizing pain helps determine the affected system. Radiation patterns are classic diagnostic clues (e.g., chest pain radiating to left arm/jaw = cardiac; flank pain radiating to groin = renal colic, epigastric pain radiating to back = AAA or pancreatitis).
S	**Severity**	• 0–10 now? worst? best? • How does it limit work/exercise/sleep?	• Establishes a baseline for monitoring. Guides urgency and treatment effectiveness. Helps distinguish between minor discomfort and potentially life-threatening pain. • High-severity pain out of proportion to physical findings (e.g., minimal tenderness but severe pain) → think ischemia (mesenteric, limb, cardiac).
T	**Timing**	• When did this start? • Constant or intermittent? • How long does it last if intermittent? • Trend since onset?	• Defines duration and evolution. Constant, unrelenting pain often signals serious pathology; intermittent pain may be colicky (e.g., gallstones, kidney stones). • A new type of pain is often more concerning than a recurrent pain the patient knows well.
AS	**Associated Symptoms**	• Are other symptoms commonly present with this complain present? • Are any common red flags present?	• Links the primary complaint to systemic involvement. For example, chest pain + diaphoresis + SOB raises suspicion for ACS; headache + neuro deficits suggests stroke. Abdominal pain + syncope suggests ruptured AAA.

	Meaning	*Example Questions*	*Clinical Pearls*
PN	**Pertinent Negatives**	• Are other symptoms commonly present with this complain absent? • Are any common red flags absent?	• Actively ruling out red-flag symptoms narrows the differential. If chest pain is not pleuritic and not reproducible, pulmonary embolism or musculoskeletal pain become less likely. • Documenting *absence* of red-flag signs (no neuro deficit, no hypotension, no pleuritic pain) protects both patient and provider.
P²	**Past Medical History**	• Have you ever had this before? is one of the most high-yield questions. • Do you have any medical conditions? • Are you taking any medications? • Do you have any drug allergies?	• Patients often recognize recurring disease (angina, asthma, seizures). • Prior diagnoses strongly inform risk (e.g., known CAD, diabetes, asthma). Recurrence of similar symptoms can suggest exacerbation vs. new disease. • Medications and allergies are important when treatment decisions are being made. • Risk factors matter: CAD, diabetes, hypertension, and smoking increase likelihood of life-threatening diagnoses.
N	**Now (Patient's perspective)**	• Why did you call 911 today? • What worries you most right now?	• Captures urgency from the patient's perspective. Even if "mild," a symptom may feel very different to the patient than prior episodes—important for decision-making and patient-centered care. • Their "gut feeling" is worth listening to—patients who say "this isn't normal for me" are often right.