

Cath Lab Assessment

Age _____ Ht _____ Wt _____ M F

List all drug allergies/reaction: _____ _____ _____ _____	List all operations and dates (include heart catheterizations) _____ _____ _____ _____
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1. Have you or a family member ever had a problem with an anesthetic other than nausea? <input type="checkbox"/> YES <input type="checkbox"/> NO		AIRWAY
2. Do you have any loose/capped teeth or dentures? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. Do you or have you ever smoked? <input type="checkbox"/> YES <input type="checkbox"/> NO		Amount: RESPIRATORY
4. Do you have a cold, cough or any breathing difficulty? <input type="checkbox"/> YES <input type="checkbox"/> NO		
5. Do you have asthma? <input type="checkbox"/> YES <input type="checkbox"/> NO		
6. Do you have sleep apnea? <input type="checkbox"/> YES <input type="checkbox"/> NO		
7. Do you have high blood pressure? <input type="checkbox"/> YES <input type="checkbox"/> NO		CARDIOVASCULAR
8. Do you have chest pain or have had a heart attack? <input type="checkbox"/> YES <input type="checkbox"/> NO		
9. Have you ever had an abnormal EKG? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10. Do you have mitral valve prolapse or heart murmur? <input type="checkbox"/> YES <input type="checkbox"/> NO		
11. Do you ever wake up short of breath or have swelling over your shins? <input type="checkbox"/> YES <input type="checkbox"/> NO		
12. Do you have coronary artery disease? <input type="checkbox"/> YES <input type="checkbox"/> NO		
13. Do you get short of breath climbing two flights of stairs? <input type="checkbox"/> YES <input type="checkbox"/> NO		
14. Have you ever had a stroke? <input type="checkbox"/> YES <input type="checkbox"/> NO		NEURO/SKELETAL
15. Have you ever had seizures, loss of vision or speech? <input type="checkbox"/> YES <input type="checkbox"/> NO		
16. Do you have back, neck, or jaw problems? <input type="checkbox"/> YES <input type="checkbox"/> NO		
17. Do you have a hiatal hernia, acid reflux, or an ulcer? <input type="checkbox"/> YES <input type="checkbox"/> NO		Amount: GI/RENAL/ENDO
18. Have you ever had hepatitis, HIV or jaundice? <input type="checkbox"/> YES <input type="checkbox"/> NO		
19. Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO		
20. Do you have kidney disease? <input type="checkbox"/> YES <input type="checkbox"/> NO		
21. Do you have diabetes? For how long? <input type="checkbox"/> YES <input type="checkbox"/> NO		
22. Do you have any bleeding disorders or anemia (low blood count)? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER/LAB
23. Have you taken aspirin, coumadin, Plavix or Lovenox in the last week? <input type="checkbox"/> YES <input type="checkbox"/> NO		
24. Have you taken any diet medications in the last month? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. Have you undergone chemotherapy or radiation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
26. Is there any chance you could be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO		
27. Do you have any medical condition(s) not listed above? <input type="checkbox"/> YES <input type="checkbox"/> NO		
28. Do you have advance directives? <input type="checkbox"/> YES <input type="checkbox"/> NO		

LEARNING NEEDS	SPIRITUAL / CULTURAL NEEDS
<p>How do you best learn? Check all that apply.</p> <p><input type="checkbox"/> TV/Video</p> <p><input type="checkbox"/> Demonstration</p> <p><input type="checkbox"/> Verbal Explanation</p> <p><input type="checkbox"/> Repetition</p> <p><input type="checkbox"/> Pictures</p> <p><input type="checkbox"/> Reading <input type="checkbox"/> Large Print</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> I would like to learn about _____</p>	<p>I would describe my present state of being as:</p> <p><input type="checkbox"/> Upbeat <input type="checkbox"/> Waiting to see <input type="checkbox"/> Somewhat anxious <input type="checkbox"/> Quite anxious</p> <p>My coping network includes:</p> <p><input type="checkbox"/> Family <input type="checkbox"/> Friends I trust <input type="checkbox"/> Depends on situation <input type="checkbox"/> Not sure who</p> <p><input type="checkbox"/> Other _____</p> <p>Are there any cultural, religious and / or spiritual practices that you need to be a part of your care?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Please Explain: _____</p>

Patient/Guardian Signature	Date

PATIENT IDENTIFICATION: