

# Cath Lab Assessment

Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_  M  F

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

<p style="text-align: center; background-color: yellow;"><b>LEARNING NEEDS</b></p> <p style="background-color: yellow;">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 style="text-align: center; background-color: yellow;"><b>SPIRITUAL / CULTURAL NEEDS</b></p> <p style="background-color: yellow;">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 style="background-color: yellow;">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 style="background-color: yellow;">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>
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Patient/Guardian Signature _____	Date _____
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PATIENT IDENTIFICATION: