Cath Lab Assessment

Age _____ Ht _____ Wt _____ ❑ M ❑ F

PATIENT IDENTIFICATION

List all drug allergies:

_____

_____

_____

_____

Latex, tape, iodine allergy?

_____

List all operations and dates (include heart catheterizations)

_____

_____

_____

_____

_____

		YES	NO
1.	Have you or a family member ever had a problem with an anesthetic other than nausea?	❑	❑
2.	Do you have any loose/capped teeth or dentures?	❑	❑

AIRWAY

3.	Do you or have you ever smoked?	❑	❑
4.	Do you have a cold, cough or any breathing difficulty?	❑	❑
5.	Do you have asthma?	❑	❑
6.	Do you have sleep apnea?	❑	❑

Amount:

RESPIRATORY

7.	Do you have high blood pressure?	❑	❑
8.	Do you have chest pain or have had a heart attack?	❑	❑
9.	Have you ever had an abnormal EKG?	❑	❑
10.	Do you have mitral valve prolapse or heart murmur?	❑	❑
11.	Do you ever wake up short of breath or have swelling over your shins?	❑	❑
12.	Do you have coronary artery disease?	❑	❑
13.	Do you get short of breath climbing two flights of stairs?	❑	❑

CARDIOVASCULAR

14.	Have you ever had a stroke?	❑	❑
15.	Have you ever had seizures, loss of vision or speech?	❑	❑
16.	Do you have back, neck, or jaw problems?	❑	❑

NEURO/SKELETAL

17.	Do you have a hiatial hernia, acid reflux, or an ulcer?	❑	❑
18.	Have you ever had hepatitis, HIV or jaundice?	❑	❑
19.	Do you drink alcohol?	❑	❑
20.	Do you have kidney disease?	❑	❑
21.	Do you have diabetes? For how long?	❑	❑

GI/RENAL/ENDO

Amount:

22.	Do you have any bleeding disorders or anemia (low blood count)?	❑	❑
23.	Have you taken blood thinners in the last week?	❑	❑
24.	Have you taken any diet medications in the last month?	❑	❑
25.	Have you undergone chemotherapy or radiation?	❑	❑
26.	Is there any chance you could be pregnant?	❑	❑
27.	Do you have any medical condition(s) not listed above?	❑	❑
28.	Do you have advance directives?	❑	❑

OTHER/LAB

LEARNING NEEDS

How do you best learn? Check all that apply.

❑ TV/Video
❑ Demonstration
❑ Verbal Explanation
❑ Repetition
❑ Pictures
❑ Reading ❑ Large Print
❑ Other _____
❑ I would like to learn about _____

SPIRITUAL / CULTURAL NEEDS

I would describe my present state of being as:

❑ Upbeat ❑ Waiting to see ❑ Somewhat anxious ❑ Quite anxious

My coping network includes:

❑ Family ❑ Friends I trust ❑ Depends on situation ❑ Not sure who
❑ Other _____

Are there any cultural, religious and / or spiritual practices that you need to be a part of your care?

❑ Yes ❑ No Please Explain: _____

Patient/Guardian Signature	Date	RN Signature	Date

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