Cath Lab Assessment

Name:_____ Age:_____ Date: _____

Height: _____Ft'_____In" Weight: _____ ❑ M ❑ F

List all medicines (including herbals)		List all drug allergies:	List all operations and dates (include heart catheterizations)
1. _____	7. _____	_____	_____
2. _____	8. _____	_____	_____
3. _____	9. _____	_____	_____
4. _____	10. _____	_____	_____
5. _____	11. _____	Latex, tape, dye allergy?	_____
6. _____	12. _____	_____	_____

	YES	NO	
1. Have you or a family member ever had a problem with an anesthetic other than nausea?	❑	❑	AIRWAY
2. Do you have any loose/capped teeth or dentures?	❑	❑	
3. Do you or have you ever smoked?	❑	❑	Amount: RESPIRATIORY
4. Do you have a cold, cough or any breathing difficulty?	❑	❑	
5. Do you have asthma?	❑	❑	
6. Do you have sleep apnea?	❑	❑	
7. Do you have high blood pressure?	❑	❑	CARDIOVASCULAR
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?	❑	❑	
14. Have you ever had a stroke?	❑	❑	NEURO/SKELETAL
15. Have you ever had seizures, loss of vision or speech?	❑	❑	
16. Do you have back, neck, or jaw problems?	❑	❑	
17. Do you have a hiatial hernia, acid reflux, or an ulcer?	❑	❑	GI/RENAL/ENDO
18. Have you ever had hepatitis, HIV or jaundice?	❑	❑	
19. Do you drink alcohol?	❑	❑	Amount:
20. Do you have kidney disease?	❑	❑	
21. Do you have diabetes? For how long?	❑	❑	
22. Do you have any bleeding disorders or anemia (low blood count)?	❑	❑	OTHER/LAB
23. Have you taken aspirin, coumadin, Plavix or Lovenox 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?	❑	❑	

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 the situation ❑ Not sure who
❑ Other _____

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

❑ Yes ❑ No Please Explain: _____

Patient/Guardian Signature	Date:

PATIENT IDENTIFICATION:

Tyler Cardiac & Endovascular Center