This flyer is designed to help you with filing out the four page *Admission History* form to prepare for your upcoming procedure

PAGE 1: Patient information. Please complete the following information on the attached pages:

- **Admitted from:** Home
- **Chief Complaint:** chest pain, Shortness of Breath, abnormal stress test, Leg pain, ASD, Tetralogy of Fallot, VSD, or reason for the procedure
- **HT:**
- **WT:** (leave blank, you will be weighed on arrival)
- **Emergency Contact:** Name, address, phone number
- **ALLERGIES:** List Drug, Food, or Substance allergies - Please list if you are allergic to IODINE, dye preparation, Shellfish, NICKEL or Jewelry allergies
- List your **MEDICATIONS** on the PRE ADMISSION MEDICATION LIST ; skip the medication section on the *ADMISSION HISTORY* form. Include PRESCRIPTION Drugs, Non-prescription, over the counter (OTC) drugs, herbal remedies, vitamins, Insulin, Inhalers
- Complete **Pain Assessment, Social Profile**, and **Psychological Profile**

PAGE 2: If you have a ***Living Will*** or ***Advance Directive*** please bring us a copy.

The Nurses at the hospital will help you with completing the rest of page 2

PAGE 3 and 4: Please complete each section.

BRING THE COMPLETED FORMS WITH YOU TO THE HOSPITAL

. The Nurses in ICAR will review the information with you when you arrive for your procedure

If you have any questions, you can E-mail the Pre-Procedural Nurse:
Theresa.bondurant@inova.org or call 703-776-7054

Directions to the INOVA Heart & Vascular Institute: From Gallows Road, come in the Gray Entrance. At the 4 way stop sign go straight. Pass the Inova Heart & Vascular Institute. Turn right into the Patient / Visitor Gray Garage. Park. Take the elevator to the ground floor. As you walk down the hall there will be a sign hanging from the ceiling " EP/ CATH check-in" turn left .

I. Patient Information

Time Admission: _____ Admitted from: _____

Chief Complaint/Associated Symptoms: _____

Ht. _____ Wt. _____ lb/kg ☐ Standing Scale ☐ Bed Scale ☐ Stated

Temp _____ Pulse _____ Resp _____ BP _____ Patient Identification Band on? ☐ Yes ☐ No

Emergency Contact: _____ PMD _____

II. Allergies

☐ Latex Sensitivity ☐ No Known Allergies ☐ Nickel or Jewelry Allergy

If yes, Allergy Band on: ☐ Yes ☐ No ☐ Charted Labeled: ☐ Yes ☐ No Entered into Computer ☐ Yes ☐ No

Food/Drug/Substance	**Type of Reaction**

III. Medications

☒ See attachment

Medications you are now taking, including: Non-Prescription, Aspirin, Birth Control Pills/Vitamins/Supplements/Herbal Remedies.

Drug/Dosage/Route	**Last Dose**

Personal Medications ☐ None ☐ Sent Home ☐ Inpatient Pharmacy ☐ Bedside

IV. Pain Assessment:

☐ Unable to obtain pain history due to patient condition.

Do you have any ongoing pain problems? ☐ Yes * ☐ No, If yes, where _____

Do you have pain now? ☐ Yes* ☐ No If yes, where _____

*If yes to either of the above describe your pain: ☐ aching ☐ burning ☐ cramping ☐ crushing ☐ dull ☐ pounding ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ tender ☐ tingling ☐ throbbing ☐ other _____

How often do you have pain (frequency)? _____

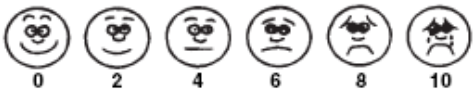
How long does the pain last (duration)? ☐ Continuous ☐ Intermittent ☐ With Movement

How long have you had this pain? _____

Using one of the following scales, indicate your present level of pain: now _____ at worst _____ at best _____

What level of pain is acceptable to you? _____

LEVEL OF PAIN



What causes or increases your pain? _____

What, if any, treatment(s) do you receive for your pain? _____

Is the treatment effective? ☐ Yes ☐ No Are the pain medications effective? ☐ Yes ☐ No

What impact does the pain have on your life and daily functioning?

V. Social Profile

Religious/Cultural Needs: Primary Language Spoken:

Interpreter Needed? ☐ No ☐ Yes If Yes, Specify: _____

Employed/Occupation: _____

Out of Country Recently? ☐ No ☐ Yes Where/When?

VI. Psychological Profile

Alcohol use ☐ Yes ☐ No How much? _____ Last used: _____

Recreational drug use: ☐ Yes ☐ No Type & how much? _____ Last used: _____

Victim of violence/abuse: ☐ Yes* ☐ No ☐ Physical ☐ Verbal ☐ Emotional ☐ Mental

Are you thinking of taking your own life? ☐ Yes * (Contacting attending MD) ☐ No

History of ☐ Alcohol abuse ☐ Drug abuse ☐ Victim of violence abuse ☐ Suicide attempt

***If yes, referral to Social Work.** ☐ **Yes** _____

PATIENT IDENTIFICATION

Name

Last, First

DOB ___/___/____
Mo/ Day/ Year

INOVA HEALTH SYSTEM

ADULT PATIENT ADMISSION HISTORY

Date: _____

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VII. Advance Directive Screening:
Do you have a living will or any other document which expresses your wishes or authorize another person to make treatment deci-sions in the event you are unable to do so? (A two-part document in which the patient gives instructions about his or her health care and/or identifies a designated decision maker when the patient cannot speak for him or herself.)

☐ ***YES***
☐ Copy of Advance Directive on chart **OR**
☐ If no copy immediately available, ask patient to provide a copy

☐ ***No***
Would the patient like more information on Advance Directives: ☐ **Yes** ☐ **No**
If yes, ☐ Booklet given

☐ ***PATIENT UNABLE TO RESPOND***
☐ Family member contacted: _____ Date: _____ Initials _____
☐ Patient has Advanced Directive per family ☐ Family member above will bring Advance Directive to hospital
Comment: _____
If not Next of Kin available, social work consult ordered in computer – Date: _____ **Initials:** _____

Are you an organ donor? ☐ Yes ☐ No ☐ Request info ☐ Information Given

VIII. Nutritional Screening
Check box for all that apply:
☐ **UNINTENTIONAL** weight loss> 10lbs. past month
☐ Tube Feeding/TPN at home
☐ Fistula/Pressure Ulcer stage 3 >
☐ Pregnant/Lactating woman (on med/surg unit)
☐ Nonelective surgical admit >80 years
☐ Unable to take food 5 days prior to admission
☐ Unable to chew or swallow
Initials:
If any criteria checked, order nutrition consult in computer. Date: _____ Initials _____

☐ Check box if no criteria apply; no consult required.
Food Intolerances: _____ (Entered by CLN command)

IX. Functional Screening (not required for rehab or joint replacement patients, as therapy orders are part of routine admission orders)
Yes ☐ NA
☐ The patient has *new* onset decreased ability to move in bed, get out of bed, stand up, or walk and is likely to improve with Physical Therapy intervention.
☐ The patient has *new* onset decreased ability to perform activities of daily living (ADL's) and is likely to improve with Occupational Therapy intervention.
☐ The patient has *new* onset of decreased ability to swallow, as indicated by history of aspiration pneumonia, coughing, or drooling and is likely to improve with Speech Therapy intervention
☐ The patient has *new* onset of decreased ability to communicate secondary to neurological disorder, tracheostomy, and/or laryngectomy and is likely to improve with Speech Therapy intervention.
If any criteria checked, obtain PT/OT or Speech Therapy consult order.

X. **Falls Screening** *(check all that apply & implement Adult Fall Interventions for any box checked)*

	Points		Points		Points
☐ History of falls	(15)	☐ Urgency/Incontinence	(15)	☐ Age (older than 70 years)	(5)
☐ Confusion	(15)	☐ Dizziness/Postural Hypotension	(15)	☐ Mobility/Unable to ambulate independently	(5)
☐ ↑ anxiety/emotional liability	(5)	☐ Sensory deficit	(5)		
☐ ↓ Level of cooperation	(5)	☐ Cardiovascular or Respiratory disease affecting perfusion & Oxygenation	(5)	☐ Medications affecting blood pressure or level of consciousness	(5)

Score Total _____ 15 or more points = High Risk Identification.

XI. Discharge Planning Do you have someone to assist you after discharge? ☐ No ☐ Yes
Do you have medical equipment at home/Specify: _____
Patient/Family Living Situation: ☐ Home Independent ☐ Home/Family Care ☐ Home/Healthcare ☐ Mental Health Inst
☐ Retirement Community ☐ Assisted Living ☐ Skilled Nsg Fac ☐ Name of Fac. _____ Other: _____
Social Resources: ☐ None Unknown ☐ Spouse/Partner ☐ Parent(s) ☐ Child(ren) ☐ Other Family
☐Home Health ☐ Substitute Decision Maker ☐ Mental Health Service(s) ☐ Dept. of Family Services ☐ Outpatient Health Clinic
☐Other: _____ ☐ Comments: _____
What complimentary therapies do you use? ☐ none ☐ chiropractor ☐ acupuncture ☐ aromatherapy ☐ other
_____

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XII. Have you ever had, or do you have any of the following? *Check only if applicable.*

ANESTHESIA HISTORY ☐ NA	YES	If Yes, Describe
Received Anesthesia		
Anesthesia Problems		
Relatives w/anes. problems		

Previous Operations/Hospitalizations

Date	Reason

CARDIOVASCULAR ☐ NA	YES	If Yes, Describe
Chest Pain/Angina		
Congestive Heart Failure		
Phlebitis/Deep Vein Thrombosis/(Blood Clot in leg)		
Edema/Swelling		
Hypertension/High BP		
Heart Attack (MI)		
Murmer/Mitral Valve Prolapse		
Pacemaker/Defibrillator		

RESPIRATORY ☐ NA	YES	If Yes, Describe
Asthma, Bronchitis, COPD Emphysema, Pneumonia		
Fatigue, Night Sweats, Tuberculosis		
Sore Throat, Cough, Cold in last 2 weeks?		Duration?
Tobacco Use		Pk/Day: # of Yrs.
Stopped Tobacco Use:		When:
Smoking Cessation Counseling given		
Oxygen Therapy, Recent Sputum Changes		

NEUROLOGICAL ☐ NA	YES	If Yes, Describe
Alzheimer's/Dementia		
Seizures		
Mental Status Changes		
Migraines, Headaches, Head Injury		
Neuromuscular Disease		
Neurovascular Disease		
Sleep Disturbances		
Stroke/TIA		
Syncope/Fainting		

VASCULAR ACCESS ☐ NA	YES	If Yes, Describe
AV fistula, Hickman, Mediport, Groshong, PICC…		

ENDOCRINE/METABOLIC ☐ NA	YES	If Yes, Describe
Diabetes/Hypoglycemia		
Pituitary/Adrenal Disease		
Thyroid Disease		

GASTROINTESTINAL ☐ NA	YES	If Yes, Describe
Change in Bowel Routine		
Constipation/Diarrhea		
GI Bleed		
Hemorrhoids		
Hiatal Hernia/Reflux		
Liver Disease/Hepatitis		
Nausea/Vomiting		
Ostomy		
Pancreatitis		
Ulcer Disease		

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XI. ***(continued)*** **Have you ever had, or do you have any of the following?** *Check only if applicable.*

HEMATOLOGIC/ONCOLOGIC	☐NA	YES	If Yes, Describe
Anemia/Sickle Cell			
Blood/Clotting Disorders			
Cancer/Tumors			
HIV Infection			
Past Blood Transfusions/ Adverse Reactions	Antibodies _____ Reaction _____		

PSYCHOLOGICAL	☐NA	YES	If Yes, Describe
Anxiety/Panic Disorder			
Have you ever had a history of psychiatric or emotional problems?			

RENAL/GENITOURINARY	☐NA	YES	If Yes, Describe
Blood in Urine			
Incontinence			
Kidney Disease/Dialysis			
Penile Discharge/Lesion			
Prostate Disease			
Sexually Transmitted Disease			
Stones/Obstruction			

Voiding Aids: ☐Ostomy ☐ Self Cath ☐ Indwelling Cath

INTEGUMENTARY	☐NA	YES	If Yes, Describe
Pressure Ulcer/Leg Ulcer/ 3rd degree burn			
Eczema/Psoriasis			

MUSCULOSKELETAL	☐ NA	YES	If Yes, Describe
Arthritis/Joint Pain			
Joint Replacement/ Any Prosthetic Devices			
Assistive Devices			
Back/Neck Pain			
Fractures			
Unable to Weight Bear			

DENTAL	☐NA	YES	If Yes, Describe
Caps, Crowns, Chipped or Loose Teeth			
Dentures/Bridgework/Retainer			
Loose Teeth			

EYES/ENT	☐NA	YES	If Yes, Describe
Hearing Deficits/Aids			
Nose Bleeds			
Sinus Disease			
Swallowing Difficulties			
Visual Deficit/Glasses/Contacts			
Glaucoma, Cataracts, Retinal Disease			

OBSTETRIC/GYN	☐NA	YES	If Yes, Describe
Possibility of Pregnancy			L.M.P date:
# of Pregnancies _0_			
# of Live Births ___0__			
Menopause			
Breast Changes			
Mammogram			Date:
Pap Smear			Date:
Menstrual Problems			
Vaginal Discharge			

Reason unable to complete within the first 24 hours: _____

Signature: _____

Date: _____ Time: _____

Thank you for Completing this Form

Information from: ☐patient ☐significant other ☐previous records ☐transfer forms

Initiated by: _____

Completed by: _____

Reviewed by: _____ **RN**

Date: _____ Time Completed: _____

PATIENT IDENTIFICATION

Name

Last, First

DOB ___/___/____
Mo/ Day/ Year

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ADULT PATIENT ADMISSION HISTORY

Date: _____

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