OUTPATIENT HISTORY This section staff use only

Verify Patient ID (2 required) ❑Name ❑DOB ❑ Other

ACTUAL HEIGHT & WEIGHT

DATE____/____/____ **AGE OF PATIENT** **PREGNANT** **BREASTFEEDING**

TIME: _____ Age _____ Height_____ Wt._____ ❑ N/A ❑Yes ❑No ❑ Yes ❑ No

PATIENT/FAMILY TO COMPLETE THE FOLLOWING:

Language Spoken_____

I. Health Problems: **Check and / or circle if you have or had any of the following?**

	Yes		Yes		Yes		Yes
Diabetes		High / Low Blood Pressure		Difficulty Swallowing		Depression / Anxiety	
Cancer_____(Type)		Pacemaker / AICD		Seizures		COPD/Pneumonia	
Asthma / Trouble Breathing		Surgical Clips/Staples		Difficulty Urinating		Unsteady Walk / Falls	
Thyroid Problems		Hepatitis / Liver Disease		Arthritis		Chest Pain	
Kidney Disease/ Surgery		Heart Problems/Disease		Stroke/TIA		Headache/ Dizziness	
Dialysis		Chemotherapy		Claustrophobia		Migraine	

II. PAIN: ❑No ❑Yes Circle number that describes the intensity of your pain: (1-3 mild, 4-7 mod, 8-10 severe) 1 2 3 4 5 6 7 8 9 10
Type / Quality: _____ Location: _____ Patient Stated Pain Goal (age appropriate scale 0-10)_____

III. Previous Surgeries: _____

IV. Medications: List all prescription and over-the-counter medications, herbal remedies, and/or supplements.

PLEASE PRINT CLEARLY

Name of Medication	Dose	How Taken	How Often	Time Last Dose	Name of Medication	Dose	How Taken	How Often	Time Last Dose

V. Medication Allergies
Have you had a true allergic reaction – such as: 1. Red rash 2. Hives 3. Swelling 4. Shortness of breath 5. Wheezing– to any drugs? ❑No ❑Yes If Yes, state name of medication, and indicate type of reaction to each: _____

VI. Medication Side Effects:
Have you had a significant side effect – such as: 1. Vomiting 2. Upset stomach 3. Diarrhea 4. Constipation 5. Headache - to any drugs? ❑No ❑Yes If Yes, state name of medication, and indicate type of reaction to each: _____

VII. ALLERGIES: Have you had an allergic reaction to food or other substance? ❑No ❑Yes If yes, list item and reaction:
_____

VIII. Latex Allergy:
When exposed to latex or rubber, (including rubber gloves used by you or your doctor, balloons, condoms) do you suffer runny nose, watery eyes, wheezing, or rash? ❑No ❑Yes, explain: _____
Do you have spina bifida or repeated catheterizations from congenital defects? ❑No ❑Yes, explain: _____
Do you have **breathing** reactions (wheezing, shortness of breath) to tropical or pitted fruits (e.g., bananas, kiwis, chestnuts, avocados, or cherries)?
❑No ❑Yes, explain_____

THIS SECTION FOR STAFF USE: IF YES HAS BEEN CHECKED OFF ONE OR MORE TIMES, USE LATEX PRECAUTIONS
❑Latex precautions indicated and initiated ❑ Latex allergy education material provided to patient
Preferred Method of Learning: ❑ Visual ❑ Auditory ❑ Written
Barriers to Learning: No cultural, religious practice, language or emotional barriers. No physical or cognitive limitations
If Yes, identify:_____
❑No Evidence of Abuse or Neglect. If evidence of abuse/neglect, Social Services notified.
❑No Special Cultural Needs Identified (i.e.-religious or dietary practices). If yes, identify_____
Patient or significant other verbalizes understanding of education/instructions. If no, provide plan for re-education in progress notes. ❑ See notes.
REVIEWED BY _____**Signature/Title** **❑ FAXED TO PHARMACY**

OUTPATIENT HISTORY and DOCUMENTATION IMAGING

872010173 (08/12)

TORRANCE MEMORIAL MEDICAL CENTER

Patient Identification

THIS PAGE FOR STAFF USE ONLY:

❑**ORDER VERIFIED**
❑**CISPLATIN/CARBOPLATIN** Date of last dose _____/_____/_____
❑**CREATININE _____/ NA** Date Drawn _____/_____/_____
❑ **IODINE CONTRAST INFORMATION SHEET REVIEWED AND SIGNED**

DRUG	DOSE	ROUTE	TIME	INITIAL	GIVEN
Morphine	2 mg	IVP			per protocol
CCK 1st dose	0.02 mg/kg	IVP over 4 minutes			per protocol
CCK 2nd dose	0.02 mg/kg	IVP over 4 minutes			per protocol
Captopril	25mg	PO			per protocol
Lasix	0.3mg/kg	IVP			per protocol
Glucagon	1mg/ml	IM _____ (site)			per protocol
Lopressor		PO			per protocol
Lopressor		IV			per protocol
NTG spray		SL			per protocol
Heparin					per protocol
Normal Saline	_____ml @ _____ hydration	IV			per protocol

Signature _____Print Name _____RN/ RT / CNMT _____ Initials
Signature _____Print Name _____RN/ RT / CNMT _____ Initials

IV started with _____ gauge catheter in_____ (site) @ _____ (time) # of attempts _____

Date: _____Time: _____ Initials: _____

VCUG - _____ Fr. Catheter inserted **Date: _____Time: _____ Initials: _____**

----------COMMENTS----------

_____
_____
_____
_____
_____
_____
_____
_____

IV catheter removed, dressing to site. Post IV contrast instructions given. Patient verbalizes understanding of instructions. **Date: _____Time: _____ Initials: _____**

❑ Reaction to contrast protocol initiated and contrast reaction sheet given to patient
❑ Extravasation protocol initiated and contrast extravasation instruction sheet given to patient.
❑ Diabetes medication instruction sheet given to patient

Date: _____Time: _____ Initials: _____

Signature _____Print Name _____RN/ RT / CNMT _____ Initials
Signature _____Print Name _____RN/ RT / CNMT _____ Initials