FIBRINOLYTIC CHECK SHEET

Cardiac Thrombolytic Therapy Screening:

Person filling out form:____

Patient Name:____ Age:________

Duration of symptoms:____/____hrs./mins.

		Yes	No
1.	S-T segment elevated or depressed at least 0.1 mv?	___	___
2.	History of bleeding problems, i.e. nose, gums, etc?	___	___
3.	History of bleeding ulcers?	___	___
4.	History of bleeding hemorrhoids?	___	___
5.	Any surgery in last 6 months?	___	___
6.	Any dental procedures in last 6 months?	___	___
7.	History of stroke (including family)?	___	___
8.	History of sudden/temporary weakness/numbness of face or extremities, dizziness or unsteadiness?	___	___
9.	History of difficulty with speech or visions?	___	___
10.	History of headaches or mental status changes?	___	___
11.	Any recent falls or injuries?	___	___
12.	History of high blood pressure?	___	___
13.	History of diabetes?	___	___
14.	History of hemorrhagic retinopathy?	___	___
15.	Pregnant?	___	___
16.	Receiving oral anticoagulants?	___	___
17.	CPR performed recently?	___	___
18.	IM injections recently?	___	___
19.	Known cardiac arrhythmias?	___	___
20.	Liver dysfunctions?	___	___