

HARMONY SURGERY CENTER, LLC
Patient Admission Assessment Form

Allergies (medications, latex, products):	
☐ None	
Do you or your responsible party need information on the following (circle needs)? None Medications Procedures Current Illness Follow-up care Diet/Nutrition Hygiene/Grooming/Oral Care Home Care Community Resources Equipment	
Preferred Learning Method (circle)? None Listening Demonstration Reading Hands-on Other:	
Barriers/Health Related Social Needs (circle): None Cognitive Hearing Education/Literacy Language Transportation Vision Emotional Physical Food or Housing Insecurity Other:	
Pain Evaluation: Current Pain? ☐ Yes ☐ No If yes: Pain level (1-10) _____ Location: Description (circle): Dull Sharp Burning Aching Current pain treatment:	
Please list any belongings you have with you: Note: HSC is not responsible for belongings. Please give all valuables to your ride home.	
Who is taking you home today? (It is recommended you have a responsible adult with you for 24 hours after procedure):	
Name of Ride: _____ Phone Number: _____	
**Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions with your ride? ☐ Yes ☐ No	

Health History:	Yes	No
Seizure/stroke or other neurological problem? Describe:		
Problems with your heart? Describe:		
Chest pressure, chest pain?		
Shortness of breath with exertion or exercise?		
☐ Pacemaker ☐ defibrillator		
☐ Cardiac stent ☐ blood vessel stent ☐ cardiac bypass		
High blood pressure?		
Blood thinner medication? Clotting problems?		
Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, Ibuprofen, etc.)? Last Dose:		
Blood disorder? Describe:		
Autoimmune disorder? Describe:		
Lung problems or problems breathing? Describe:		
Supplemental oxygen?		
Do you currently ☐ smoke ☐ Vape ☐ Tobacco products:		
Have you ever smoked? When did you quit?		
Sleep apnea ☐ CPAP ☐ Oxygen at night		
Kidney problems?		
Gastrointestinal problems?		
Frequent heartburn?		
Liver problems?		
Diarrhea or abdominal cramping? For how long?		
Diabetes and/or high blood sugar?		
☐ Thyroid ☐ Parathyroid ☐ adrenal gland problems		
Cancer:		
Have you had surgery on any of the following? ☐ Heart ☐ Brain/Spine ☐ Transplant ☐ Implants		

	Yes	No
Have you been hospitalized in the last 90 days? Describe:		
Currently have a contagious or infectious condition? Describe:		
Illness, infection or fever in the past 2 weeks?		
Taken steroids (i.e. Prednisone) in the last year?		
Suffer from: ☐ anxiety ☐ depression ☐ PTSD and/or ☐ panic attacks		
Do you smoke or consume marijuana? Last used:		
Do you use recreational drugs? Last used:		
Drink alcohol? ☐ Daily ☐ Weekly		
☐ Dentures or problems with your teeth?		
Eye or vision problems? ☐ Glasses ☐ Contacts		
Hearing problems? Hearing Aids ☐		
Use ☐ wheelchair ☐ walker ☐ cane		
Object to blood products under any circumstances?		
Problems with anesthesia (self or blood-relative)? Describe:		
Any concerns about anesthesia? Describe:		
Is there any possibility you could be pregnant? ☐ N/A		
Date of your last menstrual period? ☐ N/A		
☐ Currently breastfeeding ☐ N/A		
Circle if applicable: Menopausal ☐ Hysterectomy ☐		
Do you have an Advance Directive: ☐ CPR Directive ☐ Living Will ☐ Power of Attorney ☐ Other		
Who is your Primary Care Doctor?		
Height: _____ Weight: _____		
Signature of patient or person completing form:		
X		



Medication Reconciliation Form

****Please list all medications on this form. We are NOT able to accept a copy of your medications****

Patient: Please list all medications taken on a regular basis (including over the counter and herbal preparations).

Medication Name	Dose	Route	Frequency	Last Taken	RN to complete: Continue after discharge <u>OR</u> refer to prescribing physician:	
					CONTINUE	REFER to MD
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐
5.					☐	☐
6.					☐	☐
7.					☐	☐
8.					☐	☐
9.					☐	☐
10.					☐	☐
11.					☐	☐
12.					☐	☐
13.					☐	☐
14.					☐	☐

New Prescriptions Prescribed at HSC	Dose	Route	Frequency	Last Taken	Use
1.					
2.					
3.					
4.					

I will be provided with a copy of this list upon discharge. Please note, all routine medications marked "REFER to MD" should be clarified with the prescribing physician before continuing. **Medication Safety:** To safely manage routine and new medications, it is important to give a copy of your Medication Reconciliation Form to your primary care physician. It is also important to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added.

Patient/Responsible Party Signature: _____ Date: _____

RN Signature: _____ Date: _____