HARMONY SURGERY CENTER, LLC
Patient Admission Assessment Form

Who is taking you home today? (note – you are advised to have a responsible adult with you for 24 hours after procedure**):**

Driver Name: _____ **Driver 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

Allergies (medications, latex, products): ☐ None

Do you or your responsible party need information on the following (circle needs)? Medications Treatment/Procedures Current Illness Follow-up care Diet/Nutrition Hygiene/Grooming/Oral Care Home Care Community Resources Equipment

Preferred Learning Method (Please Circle) Listening Demonstration Reading Hands-on Other:

Barriers to learning or care (Please Circle) None Cognitive Hearing Reading/Writing Language Culture Vision Emotional Physical Financial Religion 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.

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 or defibrillator?		
Cardiac stent/blood vessel stent or cardiac bypass?		
High blood pressure?		
Blood thinner medication? Clotting problems?		
Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, Ibuprofen, etc.)?		
Blood disorder? Describe:		
Autoimmune disorder? Describe:		
Lung problems or problems breathing? Describe:		
Do you currently smoke?		
Have you ever smoked? When did you quit?		
Supplemental oxygen?		
Sleep apnea? CPAP? Oxygen at night?		
Kidney problems?		
Gastrointestinal problems?		
Liver problems?		
Diarrhea and/or abdominal cramping? For how long?		
Thyroid, Parathyroid, or adrenal gland problems?		
Cancer treated with chemotherapy or radiation?		
Have you had surgery on any of the following? ☐Heart ☐Brain/Spine ☐Transplant ☐Implants		
Have you been hospitalized in the last 90 days?		

Heath History Continued:	Yes	No
Currently have a contagious or infectious condition? Describe:		
Illness, infection or fever in the past 2 weeks?		
Diabetes and/or high blood sugar?		
Taken steroids (i.e. Prednisone) in the last year?		
Suffer from anxiety, depression, panic attacks or PTSD?		
Used recreational drug(s) within the last 3 days?		
Smoked or consumed marijuana in the past 3 days?		
Drink alcohol? ☐ Daily ☐ Weekly ☐_____		
Dentures or problems with your teeth?		
Eye or vision problems?		
Hearing problems? ☐ Hearing Aids		
Use wheelchair, walker, cane, etc.?		
Frequent heartburn?		
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		
Currently breastfeeding? ☐N/A		
Date of your last menstrual period? ☐N/A		
Do you have an Advance Directive: ❑ CPR Directive ❑ Living Will ❑ Power of Attorney ❑ Other		
Who is your Primary Care Doctor?		
Weight: **Height:**		
Signature of patient or person completing form: **X**		