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)? Medications Treatment/Procedures Current Illness Follow-up care Diet/Nutrition Hygiene/Grooming/Oral Care Home Care Community Resources Equipment

Preferred Learning Method (circle)? Listening Demonstration Reading Hands-on Other:

Barriers/Health Related Social Needs (circle): 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 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.)? Last Dose:		
Blood disorder? Describe:		
Autoimmune disorder? Describe:		
Lung problems or problems breathing? Describe:		
Supplemental oxygen?		
Do you currently smoke? Or Vape? Use tobacco products of any kind?		
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, or adrenal gland problems?		
Cancer treated with chemotherapy or radiation?		
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 use recreational drug(s)? Last used:		
Do you smoke or consume marijuana? 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		
Currently breastfeeding? ☐N/A		

Circle if applicable: Menopausal? Hysterectomy?

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?

Height: **Weight:**

Signature of patient or person completing form:

X

Harmony SURGERY CENTER

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 OR 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:_____