Patient Home Medication List – Medication Reconciliation

Provided by the Patient/Surrogate
(Include prescriptions, over the counter, herbals, vitamins and birth control pills/patch)

Allergies		
	☐ NKAS (No Known Allergies or Sensitivities)	☐ **Allergies & their reactions**
		☐ Latex/Rubber ☐ Adhesive ☐ Environmental ☐ Food (specify above)

Medications	Medication(s)	Dose	Comment
			☐ Unknown Dosage
			☐ Unknown Dosage
			☐ Unknown Dosage
			☐ Unknown Dosage
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			☐ Unknown Dosage
			☐ Unknown Dosage

Review the Allergies and Medications for the patient – Healthcare Provider Signature

Date	Preop -	OR -	PACU -
Date	Preop -	OR -	PACU -
Date	Preop -	OR -	PACU -

Patient Label

SURGERY CENTER QUESTIONNAIRE

Please Answer the Following Questions about your Health History

NOTE: This questionnaire may be used for a second visit, as long as the information is **UPDATED** and the second visit is **within 30 days** of the first visit.

Date of 1st Visit: / /	Date of 2nd Visit: / /	Date of 3rd Visit: / /

YES	NO	HISTORY	MORE INFORMATION, IF ANSWERED "YES"
		High Blood Pressure	
		Heart	□ Heart Attack □ Heart Failure □ Irregular Heart Beat
			□ Chest Pain □ Mitral Valve Prolapse
			□ Other heart related history -
		Diabetes	
		Thyroid	
		Lungs	□ Asthma □ Tuberculosis □ Emphysema
			□ Chronic Bronchitis □ Other -
		GI Problems	□ Reflux □ Other -
		Liver	□ Hepatitis □ Cirrhosis □ Yellow Jaundice
			□ Other -
		Kidneys	□ Bladder Infections □ Kidney Stones
			□ Other -
		Bleeding or Blood Clots	□ Blood Clots or DVT □ Other -
		Glaucoma	
		Neuro/Muscular	□ Muscle Disorders □ Black Out Spells □ Paralysis
			□ Stroke □ Seizures/Convulsions
			Explain -
		Dental	□ Loose Teeth □ False Teeth □ Dentures
			□ Bridges □ Capped Teeth □ Braces
		Sleep	□ Snoring □ Sleep Apnea
		Family History	Have you had a family member that has had a problem with being put to sleep for an operation?
		Hospitalizations	List any illnesses that required hospitalization -
		Surgeries	List any past surgeries -
		Social	□ Alcohol – Number of times per week
			□ Tobacco – Number of times per day
		Pregnancy	If female, what was the date of last menstrual cycle -
		Recent Illness	□ Cold/Sinus □ Other -
		Vision/Hearing	□ Do you wear contacts? □ Do you wear hearing aids?
		Medications/Allergies	NOTE: Complete the back side of this form
		Patient Rights	Are you an organ donor? (State-required information needed)
			Do you have an Advanced Directive?

To be Reviewed by the Healthcare Providers