UNION CITY
SURGERY CENTER
1722 E. Reelfoot Ave., Suite 1, Union City, TN 38261
Phone 731-885-0085 • *Fax* 731-885-3366

PATIENT MEDICATION RECONCILIATION FORM

Please fill in those areas with the *asterisks.

*Allergies *(include drugs & materials)*	*Reaction	*Allergies *(include drugs & materials)*	*Reaction

Bold Outlined Areas For Office Use Only

*Current Medication History *(include over-the-counter medication, such as herbal preparations)*	*Dose	*Frequency How many times a day	Comments	Contact prescribing MD for further orders

New Prescriptions	Dose	Frequency	Comments

Source of Medicine List: (Check all that apply)	
Patient Medication List	
Patient / Family Recall	
Pharmacy	
Primary Care Physician	
Surgeon	
Other	

Patient Label

This list is for the purpose of patient education and as such, the Facility is not responsible for the resumption of the medications or the efficacy of the listed medications.

VERIFIED _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY ASSESSMENT

Please have patient complete history assessment and medication form and bring to the Surgery Center the morning of surgery to be reviewed by Pre-Operative nurse with the Patient.

Procedure _____

ADULT and PEDIATRIC HISTORY — If applies, explain under comments **Height:** **Weight:** lbs. kg

Check All That Apply **Comments to Patient**

Lung/Breathing Problems ☐Yes ☐No
- ☐ Asthma _____
- ☐ Emphysema _____
- ☐ Bronchitis _____
- ☐ COPD _____
- ☐ Recent Cold _____
- ☐ Sleep Apnea c c-pap machine _____

Heart Disease ☐Yes ☐No
- ☐ Chest Pain _____
- ☐ Heart Attack _____
- ☐ Irregular Beats/Murmur _____
- ☐ Mitral Valve Prolapse _____
- ☐ Implanted Devices _____

High Blood Pressure ☐Yes ☐No
- ☐ Seizures _____
- ☐ Stoke _____

Paralysis or Numbness _____
☐Yes ☐No _____

Muscle Disorders _____
☐Yes ☐No _____

Stomach/Bowel Problems _____
☐Yes ☐No _____

Hepatitis/Jaundice _____
☐Yes ☐No _____

Ear/Nose/Throat Problems _____
☐Yes ☐No _____

Diabetes _____
☐Yes ☐No _____

Kidney Disease ☐Yes ☐No
- ☐ Dialysis/Vascular Graft _____
- ☐ Kidney Stones / Infections _____

Bleeding Disorders ☐Yes ☐No
- Anemia _____

History of Cancer/Treatments. _____
☐Yes ☐No

Pregnant/Last Cycle _____

Tobacco Use _____ppd _____yrs. _____

Alcohol Use - Frequency _____

Dental Problems _____Dentures _____Capped/Loose/Chipped _____

Vision/Hearing Loss ☐Yes ☐No
- ☐ Glasses _____
- ☐ Contacts _____
- ☐ Glaucoma _____
- ☐ Hearing Aids _____

Language Barrier ☐Yes ☐No ☐Other
- ☐ Interpreter/Contact Source _____

Other Medical Problems ☐Yes ☐No
- ☐ Other Serious Injuries or Illness _____

ALL SURGERIES — List

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

Personal or Family History of Anesthesia Problems:

Family history of unexpected death(s) following general anesthesia or exercise? ☐Yes ☐No

Family or personal history of malignant hyperthermia? ☐Yes ☐No

Muscle or neuromuscular disorder, high temperature following exercise? ☐Yes ☐No

Personal history of muscle spasm, dark or chocolate-colored urine? ☐Yes ☐No

Unanticipated fever immediately following anesthesia or serious exercise? ☐Yes ☐No

ALLERGIES TO MEDS / Also to include ***(Note in Red)*** reactions to **rubber latex**, iodine, tape, foods, contrast dyes, othe

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

Do you have any Cultural/Spiritual practices we need to know about?

_____

_____

***See medication reconciliation form for list of current meds taken by patier**

NURSES NOTES: _____

_____

_____

_____

☐ Advance Directive Signed.

☐ Patient Health Information is accurate as stated in assessment.

☐ Patient received information reguarding "Speak Up Program".

☐ Organ Donor ☐Yes ☐No *If Yes,* Copy Attached.

Patient Signature _____

Pre-op Nurse _____ / _____
Sedation