CENTER FOR AMBULATORY SURGERY
550 ORCHARD PARK RD. WEST SENECA, NY. 14224

PLEASE FILL OUT PRIOR TO AND BRING TO APPOINTMENT

(Please use black ink only)

GI

Sticker

Medication Reconciliation Form

List all medication that you are currently taking (include: Prescriptions, OTC, Herbals, Patches, Inhalers, Eye drops, Supplements, Vitamins, Aspirin and Oxygen)

PROCEDURE: _____

Source Key

P - Patient; F - Family; MB - Medication Bottles
MRF - Previous Medication Reconciliation Form
MAR - Another Facility Medication Form

Allergies:

	Medication Name (Print)	Source (Use Key)	Dose	Route	Frequency	If PRN/ Indication	Last Dose Date / Time	RN Initials
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

RN Signature: _____ Initials: _____ Date: _____

PREVIOUSLY PRESCRIBED MEDICATIONS WERE REVIEWED. I AM NOT AWARE THAT NEW PRESCRIPTIONS DUPLICATE CURRENT MEDICATIONS. I AM NOT AWARE OF POTENTIAL INTERACTIONS BETWEEN CURRENT (PRE-OP) MEDICATIONS AND NEW MEDICATIONS.

PHYSICIAN SIGNATURE: _____ DATE: _____

Newly Identified Discharge Medications - DOS. Source Key: Rx.P.O.S. - Physician Order Sheet, DIS - Discharge Instruction Sheet

	Medication Name (Print)	Source	Dose	Route	Frequency	If PRN/ Indication	Last Dose Date / Time	RN Signature / Initials
1								
2								
3								
4								

Form Faxed To: PMD Dr. _____ At Fax No. _____ Date: _____ Time: _____ By: _____

ALLERGIES - REACTIONS

*Should be mailed to all patients

Sticker

ALLERGY _____

REACTION _____

_____

_____

MEDICAL HEALTH HISTORY
GI UNIT

HT _____ WT _____ BMI _____

Primary Physician _____

Yes No

☐ ☐ Female: LMP/Menopausal Date _____

☐ ☐ Male: ☐ Prostate problems ☐ Radiation ☐ TURP

☐ ☐ GI Disorders: ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Diverticulosis
☐ Diverticulitis ☐ Irregular BMs ☐ Diarrhea
☐ Constipation ☐ Rectal Bleeding ☐ Hemorrhoids

☐ ☐ Heart disease ☐ HTN ☐ Heart Murmur ☐ MVP?, Antibiotics ☐ Yes ☐ No Pacemaker ☐ Defib: Type: _____
☐ Palpitations, Irregular heart beats? when _____ ? How treated _____ ☐ A-FIB
☐ ↑Cholesterol ☐ CHF ☐ MI ☐ Surgery _____ ☐ Chest Pain ☐ Dementia ☐ Alzheimer's ☐ Cardiologist

☐ ☐ Neurological Status: ☐ CVA ☐ TIA ☐ Weakness ☐ Paralysis ☐ Parkinson's _____

☐ ☐ Asthma or breathing problems; ☐ Use Oxygen; Ever in ER/Hospitalized _____

☐ ☐ Hepatitis or liver trouble _____
The CDC recommends that people born between 1945-1965 be tested for hepatitis C ☐ N/A
Have you been tested? ☐ Yes ☐ No If no, notified to contact PMD ☐

☐ ☐ Diabetes Insulin ☐ Oral ☐ Diet Controlled ☐ Blood Sugar Tested Routinely ☐ Yes FBS Result _____ ☐ No

☐ ☐ Kidney Disease / Dialysis _____

☐ ☐ Epilepsy, seizures _____ Last episode _____

☐ ☐ Eye disorders: Glaucoma ☐ Cataract R ☐ L ☐ _____

☐ ☐ Bleeding disorders, sickle cell anemia, clotting problems: DVT/PE (define) _____

☐ ☐ GI disorders: ulcer, hiatal hernia, gerd ☐ Abdominal pain ☐ Dysphagia ☐ Barrett's Esophagus

☐ ☐ Infectious disease: MRSA, VRE, open or draining wounds _____

☐ ☐ Other: CA, arthritis, muscle, joint, bone, back or disc problems, limitations: _____

☐ ☐ Family history of cancer _____

☐ ☐ Thyroid disease _____ ☐ Shingles ☐ Tuberculosis

☐ ☐ Emotional: ☐ Anxiety ☐ Depression _____

☐ ☐ Activity: ☐ Walk independently ☐ Cane ☐ Walker ☐ Wheelchair

☐ ☐ Recent illnesses/hospitalization (last few months) _____

☐ ☐ Recent piercing, tattoos (last 10-14 days)

☐ ☐ Previous surgeries: _____

_____

_____

☐ ☐ Hx of Anes. Problems MH/difficult airway or high fever - family or self? _____

☐ ☐ Do you or anyone in your family have muscular disease/Muscular Dystrophy/Multiple Sclerosis?

☐ ☐ Hx of Anes. Problem or nausea/vomiting or motion sickness? _____

☐ ☐ Emend Offered: ☐ Yes ☐ Patient Refused

☐ ☐ Drink alcohol: Amt. _____

☐ ☐ Use of Recreational Drugs: Last Used: _____ Do you take Rx pain medication daily ☐ Yes ☐ No

☐ ☐ Smoker: Packs per day ____Years ____Past smoker ☐ Yes ☐ No Quit: ____ years ago Packs per day ____ Years ____

☐ ☐ Do you have any chest pain, shortness of breath, or tire with routine activities?

R.N. Signature: _____ **Date/Time:** _____

Reviewing RN: _____ **Date/Time:** _____