Milford Regional

Medical Center

PATIENT DATA BASE

Endoscopy

Patient Name:_____ Age:_____ Date of Birth:_____ Sex ☐ M ☐ F

Height:_____ ft._____ in. Weight:_____ kgs / lbs_____ ☐ Stated ☐ Standing ☐ Bedscale

Reason for Visit:_____ Primary Care MD Name:_____

Person to Contact in Case of Emergency:

Name:_____ Relationship:_____

Phone #:_____ Alternate Phone #:_____

Do you speak English?_____ Read English?_____

If no, what is your Primary Language?_____ Read?_____ Write?_____

Do you have a health care proxy (HCP)? ☐ No ☐ Yes Copy given today: ☐ No ☐ Yes

Who will help you when you go home?_____

Are there other significant stresses in your life?_____

Is anyone hurting you (sexually, physically, or emotionally)? ☐ No ☐ Yes

How can we provide you with more comfort and security during your stay?_____

Do you smoke now? ☐ No ☐ Yes How many years?_____ How much?_____pks/day

Did you ever smoke? ☐ No ☐ Yes If so, for how many years?_____ Year quit?_____

Are you aware that Milford Regional is a smoke-free environment? ☐ No ☐ Yes

Do you now or have you ever used street drugs? ☐ No ☐ Yes

Do you drink alcoholic beverages? ☐ No ☐ Yes How often:_____ times ea._____

How much do you drink each time?_____Drinks When was your last drink?_____

Do you have pain? ☐ No ☐ Yes Location:_____Pain Level: (0-10)_____/10

Are you being treated for pain? ☐ No ☐ Yes

Are you experiencing any side effects from your treatment?_____

What makes your pain better?_____ Worse?_____

Using the 0-10 pain scale, at what pain level do you think you are able to function?_____

PREVIOUS SURGERY:

Date	Operation/Procedure	Date	Operation/Procedure

Have you or a member of you family had problems related to anesthesia or novocaine? ☐ No ☐ Yes

If Yes, describe:_____

Do you have a Cardiac Defibrilator (AICD):_____ Name of Cardiologist:_____

If yes, what brand? ☐ Medtronic ☐ Guidant ☐ Other:_____

Do you have any metal in your body? ☐ No ☐ Yes

Who is bringing you home?_____

Relationship?_____ Can we speak to them?_____ Phone #:_____

Signature of Admission RN:_____ **Date:**_____

Presently or In the past have you ever had:		*Do you currently have a problem with:*
☐ Asthma	☐ Diabetes	☐ Appetite
☐ COPD/Emphysema	☐ Thyroid Problems	☐ Bathing
☐ Tuberculosis	☐ Healing Problems	☐ Caring for yourself
☐ Chest Pain	☐ Bowel Problems	☐ Dressing
☐ Circulation Problems	☐ Digestion Problems	☐ Eating or cooking
☐ Heart Attack	☐ Kidney or Bladder Problems	☐ Falling
☐ High Blood Pressure	☐ Dialysis	☐ Falling asleep
☐ Palpitations	☐ Infectious Diseases (MRSA, VRE, C.Diff)	☐ Hearing
☐ Confusion	☐ Hepatitis	☐ Housekeeping
☐ Memory Loss	☐ Arthritis	☐ Numbness or Tingling
☐ Seizures	☐ Joint Problems	☐ Shopping
☐ Stroke	☐ Muscle Problems	☐ Smelling
☐ Cancer	☐ Emotional Problems	☐ Staying asleep
☐ Chemotherapy	☐ Psychiatric Problems	☐ Staying Safe
☐ Radiation	☐ Bleeding Problems	☐ Tasting
☐ Dietary Restrictions	☐ Other, List Below	☐ Using the Bathroom
Current Diet:_____	_____	☐ Vision
_____	_____	☐ Walking or using Stairs

Potential for Injury / Fall Risk Score for Out-Patients

Potential for Injury score	2 pts each		3 pts each		4 pts each		6 pts each	
	Age 65		Language barrier		Sensory Impaired		Unsteady on Feet	
	W/In 24 hours Postop		Laxatives or preps		Mood altering substance		Dizzy, weak, faint	
	T>101f		Incontinence		Agitation		Previous falls	
					Assistive Device for ambulation		Confused/disoriented	
					Pulling at Tubes/Drains		Wandering	
							Seizure	
							Syncope	
							Unable to follow Directions	
							CVA/TIA	

Every patient who scores 6 points or greater in the **Potential for Injury/Fall Risk Score** is **HIGH FALL RISK.**

Initiate Fall Precautions:

- **Keep side rails up**
- **Keep stretcher in low position**
- **Assist patient with ambulation**
- **Use wheelchair/stretcher for transport**
- **Orientation/re-orientation**
- **Companionship/family interaction**

Signature of RN obtaining/reviewing above information:

Name:_____ Date:_____

Milford Regional
Medical Center

OUTPATIENT SERVICES
MEDICATION RECONCILIATION FORM

Date and Time _____

Allergy/Intolerance	Reaction(s)	Allergy/Intolerance	Reactions(s)	Allergy/Intolerance	Reaction(s)
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

Medications(s) Prior to Admission
List all medications, nutritionals, herbal supplements and pumps or patches used prior to this visit or admission.

Source: ☐ Patient ☐ Family ☐ Provided List ☐ Other_____
Obtained by:_____

Medication (Include Strength)	Directions (Dose, Route, Freq)	Indication (Reason)	Last Dose (Date/Time)	Resume Meds on Discharge	Resume Date/Time
1.				YES NO	
2.				YES NO	
3.				YES NO	
4.				YES NO	
5.				YES NO	
6.				YES NO	
7.				YES NO	
8.				YES NO	
9.				YES NO	
10.				YES NO	
11.				YES NO	
12.				YES NO	
13.				YES NO	
14.				YES NO	
15.				YES NO	

(If above not completed, nurse to contact physician and review each item listed for a telephone order.)
Based on your visit to Milford Regional Medical Center, you may safely continue only the medications circled YES in the RESUME Meds on Discharge column above. If you have any questions, please contact your primary physician or surgeon.

Prescriptions Given at Discharge

Medication (include strength)	Dose/Route/Frequency	Indication	Next Dose
1.			
2.			
3.			
4.			

****Please bring this medication record with you to your physician office or on return to the hospital****

_____MD RN at Discharge_____

Date_____ Date_____

Prohibited Abbreciations: u, qd, qod, MS, MS04, MgSO4, ug, .1 (use0.1), 1.0 (use 1), SPA, CTX, IU
USE BALL POINT PEN ONLY