

PATIENT HISTORY AND PHYSICAL EXAM: (H&P must be within 30 days of procedure)

TriHealth Pre Surgical Services Fax Numbers: Good Samaritan 513-852-3895 Bethesda North 513-865-1376
 Bethesda Butler 513-454-3024 Evendale 513-247-8822 Bethesda Surgery Center 513-745-5554
 Surgery Center West 513-591-6216 Hand Surgery Center 513-961-7742 Endoscopy Center North 513-791-6013

Patient Name _____ Gender _____
 Date of Birth _____ Date of Surgery _____
 Chief Complaint _____
 History of Present Illness _____
 Diagnosis _____
 Procedure _____ Surgeon _____
 Allergies _____

PAST SURGICAL HISTORY

History of adverse reaction to anesthesia? NO YES If yes, please comment _____

Patient/Family history of malignant hyperthermia or pseudocholinesterase deficiency? NO YES

VITAL SIGNS

Ht _____ Wt _____ O2 Sat (as indicated) _____ Temp _____ BP _____ Pulse _____ Resp _____

PAST MEDICAL HISTORY (Check if applicable)	COMMENTS
Cardiovascular <input type="checkbox"/> CAD <input type="checkbox"/> MI <input type="checkbox"/> CHF <input type="checkbox"/> CVA <input type="checkbox"/> Hypertension <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Pulmonary Embolus <input type="checkbox"/> Internal Defibrillator <input type="checkbox"/> Valvular Disease <input type="checkbox"/> Pacemaker <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Deep Vein Thrombosis	
Pulmonary <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Steroid Dependent <input type="checkbox"/> Recent Respiratory Infection <input type="checkbox"/> O2 Dependent <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP	
Endocrine <input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Years _____ <input type="checkbox"/> Thyroid Disease	
Genitourinary <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Dialysis Dependent <input type="checkbox"/> Chronic Renal Disease/Insufficiency	
Gastrointestinal <input type="checkbox"/> Jaundice/Hepatitis <input type="checkbox"/> Hiatal Hernia/GERD <input type="checkbox"/> Ulcer	
Musculo-Skeletal <input type="checkbox"/> Neck Pain <input type="checkbox"/> Back Pain	
Dermatology <input type="checkbox"/> Psoriasis <input type="checkbox"/> Shingles <input type="checkbox"/> Ulcer <input type="checkbox"/> Bruises or Bleeds Easily	
Neurological <input type="checkbox"/> Seizure <input type="checkbox"/> Parkinsons <input type="checkbox"/> Dementia <input type="checkbox"/> Paralysis <input type="checkbox"/> Myasthenia Gravis	
OB/Gyn <input type="checkbox"/> Pregnant Weeks _____ <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> LMP <input type="checkbox"/> Menopausal	
Psychiatric/Behavioral <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> PTSD <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other	
Miscellaneous/Other <input type="checkbox"/> Anemia Type _____ <input type="checkbox"/> Cancer <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> HIV <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blood Dyscrasia <input type="checkbox"/> Other	
Recent infection or exposure to contagious disease? <input type="checkbox"/> No <input type="checkbox"/> Yes	

MD/Examiner's Signature _____ Date _____ Time _____

PHYSICIAN SIGNATURE DATE/TIME REQUIRED ON EVERY PAGE



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PATIENT IDENTIFICATION LABEL

Patient Name _____ Date of Birth _____

SOCIAL HISTORY	Tobacco use ever? <input type="checkbox"/> No <input type="checkbox"/> Yes	Smokeless Tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes
	If yes, packs per day _____	Pack years _____
	Alcohol use? <input type="checkbox"/> No <input type="checkbox"/> Yes	If ex-smoker, quit date _____
	Recreational drug use? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, drug type _____
FAMILY HISTORY <input type="checkbox"/> Problems with anesthesia <input type="checkbox"/> Bleeding or clotting problems		
<input type="checkbox"/> Other _____		

MEDICATION LIST Additional medication list attached

Medication Name	Dose	Frequency

REVIEW OF SYSTEMS	WNL	N/A	COMMENTS
Constitutional	<input type="checkbox"/>	<input type="checkbox"/>	
Head (Eye, Ear, Nose & Throat)	<input type="checkbox"/>	<input type="checkbox"/>	
Breast	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	
Hematologic/lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric/Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	

PHYSICAL EXAM	WNL	N/A	COMMENTS
Head (Eye, Ear, Nose & Throat)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Breast	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Pelvic and Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	

FUNCTIONAL CAPACITY (for all patients) Check level to reference maximum capacity

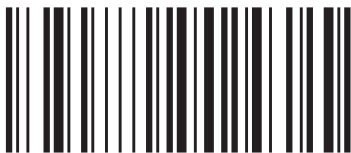
<input type="checkbox"/>	1-3 Met Eat, dress, walk indoor around house	<input type="checkbox"/>	3-5 Mets: Light work around the house, Climb stairs Runs short distance, Heavy housework
<input type="checkbox"/>	5-7 Mets Easy digging in garden, Singles tennis	<input type="checkbox"/>	7-9 Mets: Carrying 20 lbs while climbing stairs Heavy shoveling

Plan of Care: _____

- Patient may proceed with planned surgery as scheduled
- Additional pertinent information attached (labs, reports, etc)
- Pending clearance from _____ List name/specialty _____

MD/Examiner's Signature _____ Date _____ Time _____

PHYSICIAN SIGNATURE DATE/TIME REQUIRED ON EVERY PAGE



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PATIENT IDENTIFICATION LABEL