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 ☐ CAD ☐ MI ☐CHF ☐ CVA ☐ Hypertension ☐ Arrhythmia ☐ Pulmonary Embolus ☐ Internal Defibrillator ☐ Valvular Disease ☐ Pacemaker ☐ Peripheral Vascular Disease ☐ Deep Vein Thrombosis	
Pulmonary ☐ Emphysema/COPD ☐ Asthma ☐ Steroid Dependent ☐ Recent Respiratory Infection ☐ O2 Dependent ☐ Sleep Apnea ☐ CPAP	
Endocrine ☐ Diabetes ☐ Type I ☐ Type II ☐ Insulin Dependent ☐ Years ____ ☐ Thyroid Disease	
Genitourinary ☐ Kidney Disease ☐ Dialysis Dependent ☐ Chronic Renal Disease/Insufficiency	
Gastrointestinal ☐ Jaundice/Hepatitis ☐ Hiatal Hernia/GERD ☐ Ulcer	
Musculo-Skeletal ☐ Neck Pain ☐ Back Pain	
Dermatology ☐ Psoriasis ☐ Shingles ☐ Ulcer ☐ Bruises or Bleeds Easily	
Neurological ☐ Seizure ☐ Parkinsons ☐ Dementia ☐ Paralysis ☐ Myasthenia Gravis	
OB/Gyn ☐ Pregnant Weeks ____ ☐ Tubal Ligation ☐ LMP ☐ Menopausal	
Psychiatric/Behavioral ☐ Depression ☐ Anxiety ☐ PTSD ☐ Bipolar ☐ Schizophrenia ☐ Other	
Miscellaneous/Other ☐ Anemia Type _____ ☐ Cancer ☐ Prostate Disease ☐ Sickle Cell Disease ☐ HIV ☐ Glaucoma ☐ Blood Dyscrasia ☐ Other	
Recent infection or exposure to contagious disease? ☐ No ☐ 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? ☐ No ☐ Yes Smokeless Tobacco? ☐ No ☐ Yes
If yes, packs per day _____ Pack years _____ If ex-smoker, quit date _____
Alcohol use? ☐ No ☐ Yes If yes, drinks per week _____
Recreational drug use? ☐ No ☐ Yes If yes, drug type _____

FAMILY HISTORY ☐ Problems with anesthesia ☐ Bleeding or clotting problems
☐ Other _____

MEDICATION LIST ☐ Additional medication list attached

Medication Name	Dose	Frequency

REVIEW OF SYSTEMS	WNL	N/A	COMMENTS
Constitutional	☐	☐	
Head (Eye, Ear, Nose & Throat)	☐	☐	
Breast	☐	☐	
Respiratory	☐	☐	
Cardiovascular	☐	☐	
Gastrointestinal	☐	☐	
Genitourinary	☐	☐	
Integumentary	☐	☐	
Hematologic/lymphatic	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Endocrine	☐	☐	
Psychiatric/Behavioral	☐	☐	

PHYSICAL EXAM	WNL	N/A	COMMENTS
Head (Eye, Ear, Nose & Throat)	☐	☐	
Heart	☐	☐	
Breast	☐	☐	
Lungs	☐	☐	
Abdomen	☐	☐	
Pelvic and Genitalia	☐	☐	
Extremities	☐	☐	

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

☐	1-3 Met Eat, dress, walk indoor around house	☐	3-5 Mets: Light work around the house, Climb stairs Runs short distance, Heavy housework
☐	5-7 Mets Easy digging in garden, Singles tennis	☐	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