TriHealth
Orthopedic & Sports Institute

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Enclosed is a History and Physical form to be **completed by your Family Physician.**

PLEASE DON'T TRY TO FILL OUT THE FORM.

Please **make an appointment to have this form completed within Thirty (30) days of your scheduled surgery.** Your Physician needs to Fax a copy of the form to the Hospital, and you need to take the completed form with you on the day of your surgery.

If you are under the care of a **Cardiologist or Pulmonary Physician**, you will need to get a written medical clearance from them. Have your physician to fax in to our office @ 246-2394.

If you have *ANY PROBLEMS* getting in to see your Physician and /or getting the form completed; please contact the surgery scheduler @ (513) 246-2326.

PLEASE NOTE: Occasionally, as it gets closer to your surgery date the start time may need to be adjusted, for one reason or another. If this happens, you will be notified immediately.

If you need to ***cancel or reschedule*** your surgery Please call the scheduler as soon as possible.

Kenwood Office
8311 Montgomery Road
Cincinnati, OH 45236

Mason Office
7450 Mason-Montgomery Road
Suite 104
Mason, OH 45040

West Chester Office
4900 Wunnenberg Way
West Chester, OH 45069

Main 513 246 2300
Fax 513 246 2391
TriHealth.com

10615 Montgomery Road, Ste 300 • Cincinnati, OH 45242 • Main Number – (513)346-6900 • PreAdmission Testing Direct – (513) 346-6901 • PreAdmission / Scheduling Fax – (513) 745-5554

To Surgery Patients:

Please take this form along with the History and Physical form provided to you by your surgeon to your appointment for the pre-surgery workup. The History and Physical (H&P), plus any necessary testing prior to your surgery **must be completed within 30 days of your surgery.**

- ***Patients who are unable to make an appointment with their primary physician, or do not have a primary physician, please contact the PAT department immediately at (513) 346-6901***

To Primary Care Physician:

Physicians completing H&P please order the following at the time of appointment

EKG *- If patient, 60 years or older, has history of MI , heart surgery, or cardiac arrhythmia; have history of CVA, TIA; has greater than 10 years of diabetes or hypertension; has End Stage Renal failure, and if no EKG within the last 6 months.* ***No EKG for MAC anesthesia cases***
*****For patients under the care of a cardiologist or pulmonologist, please obtain and forward to our facility:*** ***Cardiac*** *– Last cardiology note, prior EKG, last angiogram, last echocardiography report, and last stress test* ***Pulmonary*** *- Last pulmonary function tests (PFTs) and last imaging studies (CXR, CT, etc) if scheduled for* ***UPPER EXTREMITY SURGERY ONLY.*** ***Requests for specialist clearance will then be made (if necessary) after testing/notes have been reviewed***
CBC *- If patient has recent history of anemia, bleeding, or blood disorder* ***BMP (Basic Metabolic Panel)*** *– If patient is diabetic; taking blood pressure medication/combination with a water pill, or on diuretic medication* ***Potassium Level*** *– for all dialysis patients* ***on day of surgery***

Important information for Primary Care Physicians and Patients:

- Blood work and/or diagnostic testing must be within 30 days of the surgery. If blood work is older it will need to be re-ordered prior to surgery.
- Fax the completed H&P and any pertinent information to (513) 745-5554.
- Patients should receive a copy of their completed H&P and bring a copy with them day of surgery.
- **The Surgery Center can not accept results from patient's at home machines – (i.e. Accucheck, PT/PTT etc).**
- When ordering blood work or diagnostic testing please add to order "copy to Bethesda Surgery Center" with fax # (513-745-5554)
- Any further questions or concerns please contact Bethesda Surgery Center's PAT RN at (513) 346-6901

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

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

PATIENT IDENTIFICATION LABEL