Bethesda
Surgery Center | TriHealth

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

Bethesda
Surgery Center | TriHealth

10615 MONTGOMERY RD. SUITE 300
CINCINNATI, OHIO 45242
MAIN (513) 346-6900
MAIN FAX (513) 745-5555
PREADMISSION TESTING (513) 346-6901

Patient Label

COMPREHENSIVE HISTORY AND PHYSICAL

Name of Patient ______________________ Patient's Date of Birth ___/___/___
Date of Examination ______________ M.D.completing ______________ (Please Print)

Office Phone # ______________ Office Fax # ______________

Diagnosis ______________ Planned Procedure ______________
Surgeon Performing Procedure ______________ Date of Surgery ______________

HISTORY OF PRESENT ILLNESS / INJURY

Chief Complaint:
Location:
Duration:
Severity: (Pain Level 0-10)
Symptoms:

MEDICAL HISTORY

Allergies/Sensitivity: ______________
Previous anesthesia history: ______________

PERTINENT PAST, FAMILY, AND/OR SOCIAL HISTORY

Comments ______________

*****LIST ON SEPARATE SHEET IF ADDITIONAL ROOM IS NEEDED******

PREVIOUS SURGERY (LIST PROCEDURES AND DATES)

Procedure	Date

**********LIST ON SEPARATE SHEET IF ADDITIONAL ROOM IS REQUIRED*********

MEDICATION LIST

Drug Name	Dosage	Frequency

*****LIST ON SEPARATE SHEET IF ADDITIONAL ROOM IS REQUIRED*****

(Comprehensive History and Physical Continued on the back)

Bethesda
Surgery Center | TriHealth

Patient Name________________________________ **Patient's Date of Birth** ____________________

COMPREHENSIVE HISTORY AND PHYSICAL
PHYSICAL EXAMINATION

Height__________Weight__________BP__________T__________P__________R__________

	WNL	ABNORMAL	N/A	COMMENTS
Head Eye, Ear, Nose & Throat	☐	☐	☐	
Heart	☐	☐	☐	
Breast	☐	☐	☐	
Lungs	☐	☐	☐	
Abdomen	☐	☐	☐	
Pelvic and Genitalia	☐	☐	☐	
Extremitics	☐	☐	☐	
Neurological Exam	☐	☐	☐	
Other	☐	☐	☐	

REVIEW OF SYSTEMS

	WNL	ABNORMAL	N/A	COMMENTS / PHYSICIAN TREATING
Constitution	☐	☐	☐	
Ear, Nose, Throat	☐	☐	☐	
Cardiovascular	☐	☐	☐	
Gastrointestinal	☐	☐	☐	
Genitourinary	☐	☐	☐	
Musculoskeletal	☐	☐	☐	
Integument	☐	☐	☐	
Neurological	☐	☐	☐	
Endocrine	☐	☐	☐	
Hematological	☐	☐	☐	
Lymphatic	☐	☐	☐	
Immunological	☐	☐	☐	
Psychiatric	☐	☐	☐	

******LIST ON SEPERATE SHEET IF ADDITIONAL ROOM IS NEEDED*****

PHYSICIAN STATEMENT

This patient is / is not (circle one) cleared for surgery in an ambulatory setting

________________________________ / ________________ / ______________**AM / PM**
Physician's Print / Signature (Required) Date Time

FAX THIS FORM (both sides) AND ALL RELATED TESTING RESULTS
PRIOR TO THE DATE OF SURGERY TO
513-745-5554