HISTORY AND PHYSICAL

Patient Name _____ DOB_____
ChiefComplaint/ProvisionalDiagnosis_____
History of Present Illness _____
Allergies:_____ Reactions:_____

Past pertinent history/chronic diseases impacting procedure planned or anesthesia management ***(Mandatory: Check all that apply)***

- ☐ AIDS/ HIV positive/ARC
- ☐ Blood Clots/ Emboli
- ☐ Chest Pain/Angina/MI
- ☐ Cancer/Solid Tumor (metastatic)
- ☐ Cancer Chemotherapy (ongoing)
- ☐ Chronic Dialysis
- ☐ Convulsions/Epilepsy
- ☐ COPD/Asthma/Bronchitis/Emphysema
- ☐ CVA/Stroke/TIA (history of)
- ☐ Cirrhosis (Hepatic)
- ☐ Diabetes Mellitus
- ☐ Glaucoma
- ☐ Heart Surgery/CABG/Pacemaker
- ☐ Hepatic Failure w/coma or Encephalopathy
- ☐ Hypertension
- ☐ Immunosuppression
- ☐ Ischemic Heart Disease/CHF
- ☐ Leukemia/AML/CML/Multiple Myeloma
- ☐ Lymphoma
- ☐ PVD-Peripheral Vascular Disease
- ☐ Sleep Apnea
- ☐ Thyroid Disease

Pertinent family history:_____
Pertinent social history: _____
Date of last visit:_____ Findings:_____
Vital Signs: B/P _____ T_____ P _____ R_____Ht_____ Wt _____kg _____lbs
Present Health Status:_____

Systematic Review: Code description: x = Abnormality, WNL = within normal limits

System	Code	Description/Status/Abnormal Findings
Cardio-Vascular		
EENT		
Endocrine		
Gastrointestinal		
General		
Locomotor		
Neck		
Neuropsychiatric		
Reproductive		
Respiratory Function		
Skin		
Urinary		

Patients Name
Surgeon
Patients # and Date

OVER

HISTORY AND PHYSICAL

For children and adolescents:

Evaluation of patient's developmental age: ☐ Age- appropriate ☐Other _____

_____

Immunization Status: ☐ Up to Date ☐ Other _____

History of Infection: ☐Hepatitis ☐MRSA ☐VRE ☐ C-DIFFICILE ☐ACINETOBACTER ☐OTHER_____

Medications and dosages: (*including herbal, OTC, and home remedies*)

☐ List attached ☐ Medications Reviewed and Reconciled with proposed treatment plan

_____

_____

Pain Assessment:

Pain associated with condition for which the patient is seeking treatment ☐ YES ☐ NO

Describe:_____

_____

Pain Scale 1 2 3 4 5 6 7 8 9 10 (10 being the worst)

Impressions/Plan_____

_____

☐ The patient has been cleared for surgery in an ASC.

_____ **DPM/MD/DO** _____

PHYSICIAN SIGNATURE **DATE/TIME**

_____ **CRNA** _____

ANESTHESIA PRACTITIONER SIGNATURE **DATE/TIME**

**Original H&P within 30 days of procedure updated day of procedure.*

I have reviewed the H&P performed on _____. ***

There □ *are no changes*

□ *are changes, as follows:*_____

_____ DPM/MD/DO _____

PHYSICIAN SIGNATURE DATE/TIME

Patients Name
Surgeon
Patients # and Date

CHARDON SURGERY CENTER

INSTRUCTIONS BEFORE SURGERY

You have been scheduled for your procedure_____at Chardon Surgery Center.

In order to receive your arrival time and other pertinent information, the Pre/Post Operative Care Unit will contact you the day before your surgery. If your surgery is scheduled for Monday, you will be contacted on Friday. If you have not been contacted by 3:00 PM, please call ***Chardon Surgery Center at 440-285-2900.***

We ask that you notify the office/physician of any changes in your condition or health such as fever, cold, rash, etc. For any questions or concerns regarding your procedure, please contact your surgeon at **440-285-2020**.

1. MEDICATIONS — To minimize the risk of blood loss during your surgery, you must avoid or stop taking medications that contain aspirin, that are anti-inflammatory medications, or contain blood thinning agents. These should be discontinued 7-10 days prior to your surgery. This includes Vitamins, Herbs and Supplements for they too may contain blood thinning components. If you are taking any blood thinners or insulin, notify your surgeon at the time of your visit; you may need to be evaluated by the prescribing physician prior to your procedure. You may take extra-strength Tylenol and Tylenol based medications such as Darvocet and Vicodin. Blood pressure medications and cholesterol medication may also be continued up to the date of your surgery.

2. PRESCRIPTIONS — Bring a list of your current medications; however do not bring any medications with you from home.

3. FOOD — Unless you are scheduled for local anesthetic, you will need to be NPO (nothing by mouth) after midnight of the night before your surgery and on the morning of your surgery. If you are a diabetic, please check with us for special instructions.

4. SAFETY — If you are receiving anesthesia or sedation for your surgery, you must have a responsible adult drive you home from the Center and remain with you for 24 hours after surgery. **You cannot drive for 24 hours following your procedure.**

5. BATHING — A bath or shower should be taken with antibacterial soap the evening before or the morning of surgery. You should wash your hair. No facial makeup should be worn the day of surgery. Body lotions and creams should be avoided as well.

6. CLOTHING — Wear a comfortable pair of pants and shirt or blouse with a wide neck opening or button front shirt that is easy to change. All jewelry, watches, and/or valuables should be removed and left at home the day of surgery.

7. APPLIANCES — On the day of your surgery, you may wear your dentures and hearing aids, as well as your glasses and contact lenses. Bring your glass or contact case with you.

8. SURGICAL SITE INFECTIONS — A surgical site infection is an infection that develops within 30 days after an operation, or, if an implant was placed, within one year and the infection appears to be related to the surgery. In order to help prevent such an occurrence, it is critical that you follow your doctor's orders regarding showering with an antiseptic soap and the taking of pre-operative antibiotics. In addition, post-op orders and general hygienic care such as washing your hands before touching the surgical areas and the taking of post-operative medications as ordered are critical. If you suspect you may have a surgical site infection please notify your surgeon.

PLEASE BRING A PHOTO ID AND YOUR CURRENT INSURANCE CARDS THE DAY OF SURGERY.

Additional Instructions/Comments: _____

_____

The center is located outside the main doors of our Chardon office at 150 Seventh Ave, Chardon, Ohio 44024.

Chardon Surgery Center
150 Seventh Avenue
Chardon Ohio, 44024
Phone: 440-285-2900
Fax: 440-286-2905

Patient: _____ DOB: _____

The Patient listed above has been scheduled for:

_____

_____

on _____at the *Chardon Surgery Center.*

The patient will need the following tests that are checked below for their scheduled procedure.

__X__ **Medical Clearance Letter & History and Physical (attached form)**

____ Cardiac Clearance Letter

____ EKG

____ Chest X-ray

____ CBC

____ BMP

____ Urinalysis

____ PT/PTT/INR

____ Copy of Stress test

____ Other

All requested information and testing must be completed ***within 30 days*** of the scheduled date of surgery.

Please fax the results to these tests to our office at **440-286-2905.**

Please feel free to include any additional testing that you may deem necessary.
Thank you for your assistance.

Ordering Physician:
Ophthalmology & Oculoplastic Surgery, Inc.
150 Seventh Avenue Suite 100
Chardon, Ohio 44024
440-285-2020