Beacon Orthopaedics Surgery Center
fax # 513-823-2887
Kirsten Hechler RN, BSN
Email khechler@beaconortho.com

Patient_____ **D.O.B.**_____
Surgery date_____
Surgical Procedure_____

	Medical History *Circle if Applicable*	**Assessment**				**Previous Surgery YES □ NO □**
		Sys	**NOR**	**ABN**	**Comments**	List:
1	Cold / Chronic Cough / Tuberculosis	HEENT				
2	Bronchitis / Emphysema/ OSA					
3	Asthma / Shortness of Breath	NECK				
4	Rheumatic Fever / Heart Murmur					
5	High Blood Pressure	CHEST				
6	Swelling of Feet / Fluid in Lungs					
7	Heart Attack	HEART				**Allergies YES □ NO □**
8	Irregular, Fast Heartbeats					List:
9	Bruises, Bleeding Easily	ABDOMEN				
10	Sickle Cell Anemia / Anemia					
11	Diabetic / Low Blood Sugar	EXTREM.				
12	Pregnant: No.of weeks _____					
13	Kidney Disease	**M.D. Notes**				**Medications YES □ NO □**
14	Jaundice / Hepatitis					List:
15	Hiatal Hernia / Ulcer/ GERD					
16	Convulsioins / Epilepsy / Stroke					
17	Meningitis / Paralysis					
18	Back Pain / Slipped Disc / Arthritis					
19	Psychological Disease					
20	Thyroid Disease					
21	Glaucoma					
22	Skeletal Deformities/ Disease					
23	Loose Teeth / Caps on Front Teeth					
24	History Anesthesia Complications					
	Self / Family					
25	Cancer / Leukemia / HIV	**** K if on Diuretics***				
Smoker : Pack / Day		**** EKG needed for 50 or older or***				**Family History:**
Alcohol intake:		***cardiac history***				
Drug Abuse:						
Menstrual History:						
Menopause:						
Hysterectomy:						
LMP		***Patient is medically cleared for surgery***				
VS		YES □ NO □				
Height						
Weight		**Physician's Signature/ Date**				

BEACON
Orthopaedics & Sports Medicine

TEL: 513.354.7657 FAX: 513.823.2887

www.BeaconOrtho.com

BEACON ORTHOPAEDICS SURGERY CENTER

PRE-OPERATIVE TESTING ORDERS FOR TOTAL HIP AND PARTIAL/TOTAL KNEE ARTHROPLASTY

***Please give this form to your Primary Care Physician to fill out and fax to Beacon within 30 days of your surgery, but at least 7 days prior to surgery.**

Patient's Name: _____

Pre-Operative Diagnosis: _____

Surgical Procedure: _____

Surgery Date: _____

History and Physical – within 30 days of surgery date

Please draw the following labs on EVERY patient: within 30 days of surgery date

a. CBC w/cell count and differential
b. BMP
c. PTT & PT/INR Required due to Spinal Anesthesia-if pt on Blood Thinners get PTT &PT/INR 24hours before surgery
d. A1C if diabetic

EKG – All patients 50 years of age or older regardless of cardiac health within 3 months or patients with history of cardiac disease, MI, Angina, Stent placement or CABG

The following is to be ordered by PCP and/or Anesthesiologist

Chest X-Ray – Only if clinically indicated by changes in condition of the patient suggesting unstable cardiac or pulmonary condition.

Other: _____

_____ _____

Physician Signature Date

*****If the patient is on Warfarin, the PT/INR level should be drawn 2 days prior to their procedure after stopping their Warfarin**

****Fax all testing plus history and physical to (513) 823-2887 at least 72 hours prior to surgery date**