Children's National™
111 Michigan Avenue, NW,
Washington, DC 20010

Surgeon's office to complete the following:

Fax completed form to*:* _____ *Date of surgery :* _____

Surgical History & Physical - Interdisciplinary Patient Assessment

Chief Complaint: _____
History of Present Illness/Injury: _____
_____

Is the patient in pain?: YES NO If Yes, complete:

Wong-Baker Faces Pain Rating Scale
(Recommended for children ≤ 3 year)

Numeric Scale
(For older children and adolescents)

Location: _____ Duration:_____
Frequency: _____ Character: ☐ Dull ☐ Sharp ☐ Throbbing

Review of Systems (circle if the patient has had a recent):
Cough Rhinorrhea Fever Pneumonia (in preceding 4 weeks) Diarrhea Nausea/Emesis
Other:_____

Call Pre-Operative Care Clinic (202-476-5966) or Surgeon's office if the following:
Wheezing in the past week Recent fever > 100.7°F or 38°C Pneumonia in the prior 4 weeks

Past Medical / Surgical History (circle if the patient has or has had):

Asthma/Reactive Airway Disease	☐ Yes	☐ No	Congenital heart disease	☐ Yes	☐ No
Allergies/Reactions	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Bleeding Disorder/Tendency	☐ Yes	☐ No	GERD	☐ Yes	☐ No
Family h/o anesthesia problem	☐ Yes	☐ No	Prematurity	☐ Yes	☐ No

Other/Describe Positive: _____

Family History/Psychosocial Assessment: _____

Immunizations Up To Date: Yes No **Date of Last Menstrual Period** _____N/A_____

Current Medications: _____
_____

PLEASE TURN OVER →

HNP

Legend: Place an 'X" if abnormal, "√" if normal, and leave blank if not examined.

Physical Exam

Temp:_____ HR:_____ RR:_____ BP:____/____ HT: _____ WT: _____ HC: _____

Mandatory:

☐ **Cardiovascular** _____ ☐ **Lungs** _____

If Applicable:

☐ General Appearance (State) _____

☐ Head / Fontanel _____

☐ Ears _____

☐ Eyes _____

☐ Nose _____

☐ Mouth / Teeth / Pharynx _____

☐ Lymph Nodes _____

☐ Abdomen _____

☐ Genitals _____

☐ Anus / Rectum _____

☐ Skin / Scalp _____

☐ Neurological _____

☐ Skeletal (Back, Hip, Extremities) _____

☐ Development / Growth _____

☐ Other, describe _____

Labs / Radiology (if pertinent): _____

Assessment (Medical /Surgical Indications for Admission): _____

Plans: _____

(Mandatory) Education: ☐ Diagnosis, medications, & treatment plan discussed and reviewed with patient / family.

I certify that I have examined this patient and the patient is medically cleared for surgery:
(Mandatory) Physician/LIP Signature: _____ Print Name:_____

Date: _____ Time:_____

Surgical Attestation: I have confirmed the history and physical as documented and examined the patient. The indications for surgery remain unchanged (any changes have been documented).

Surgery Attending Signature: _____ Date: _____ Time:_____
Print Name: _____

24 Hour Update: I have seen and examined this patient, concur with the documented history, physical examination, assessment and plan.

Surgery Attending Signature: _____ Date: _____ Time:_____

Print Name: _____

HNP