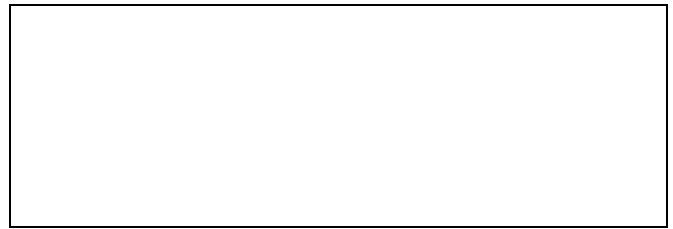




**Children's National**  
 111 Michigan Avenue, NW,  
 Washington, DC 20010



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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergies/Reactions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder/Tendency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	GERD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family h/o anesthesia problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prematurity	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> General Appearance (State) | <input type="checkbox"/> Mouth / Teeth / Pharynx | <input type="checkbox"/> Skin / Scalp                      |
| <input type="checkbox"/> Head / Fontanel            | <input type="checkbox"/> Lymph Nodes             | <input type="checkbox"/> Neurological                      |
| <input type="checkbox"/> Ears                       | <input type="checkbox"/> Abdomen                 | <input type="checkbox"/> Skeletal (Back, Hip, Extremities) |
| <input type="checkbox"/> Eyes                       | <input type="checkbox"/> Genitals                | <input type="checkbox"/> Development / Growth              |
| <input type="checkbox"/> Nose                       | <input type="checkbox"/> Anus / Rectum           |  |
| <input type="checkbox"/> 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\*