Surgeon’s office to complete the following:
Fax completed form to: ___________________________ Date of surgery: ___________________________

Contact your surgical scheduler or surgeon’s office if the following:
Wheezing/cough in the past week   Recent fever > 100.7°F or 38°C   Pneumonia/flu in the prior 4 weeks

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: __________________________

Past Medical (select if patient has or has had):
Asthma/Reactive Airway □ Yes □ No   Congenital Heart □ Yes □ No
Disease
Tracheostomy □ Yes □ No   Heart Murmur □ Yes □ No
Bleeding Disorder/Tendency □ Yes □ No   GERD □ Yes □ No
Allergies/Reactions □ Yes □ No   Prematurity □ Yes □ No
Genetic Disorder □ Yes □ No   Renal Disease □ Yes □ No
Neurologic Disorder □ Yes □ No   Family h/o Anesthesia □ Yes □ No
Problem
Other/Describe Positive: ______________________________________________________

Surgical History: ___________________________________________________________

Family History/Psychosocial Assessment: _______________________________________

Immunizations Up To Date: Yes No Date of Last Menstrual Period _______________ N/A

Current Medications & Dose: ____________________________________________________

__________________________________________________________________________

PLEASE TURN OVER
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)
- [ ] Mouth / Teeth / Pharynx
- [ ] Skin / Scalp
- [ ] Head / Fontanel
- [ ] Lymph Nodes
- [ ] Neurological
- [ ] Ears
- [ ] Abdomen
- [ ] Skeletal (Back, Hip, Extremities)
- [ ] Eyes
- [ ] Genitals
- [ ] Development / Growth
- [ ] Nose
- [ ] Anus / Rectum
- [ ] Other, describe

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**Labs / Radiology** (if pertinent):
________________________
________________________
________________________
________________________
________________________

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**Assessment** (Medical /Surgical Indications for Admission):
________________________
________________________
________________________
________________________
________________________

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**Plan:**
________________________
________________________
________________________
________________________
________________________

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**(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: ____________

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**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: ____________________________

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**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: ____________________________