Children's National

111 Michigan Ave NW
Washington, DC 20010

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)

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Numeric Scale
(For older children and adolescents)

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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
- Tracheostomy □ Yes □ No
- Bleeding Disorder/Tendency □ Yes □ No
- Allergies/Reactions □ Yes □ No
- Genetic Disorder □ Yes □ No
- Neurologic Disorder □ Yes □ No

Congenital Heart Disease □ Yes □ No
- Heart Murmur □ Yes □ No
- GERD □ Yes □ No
- Prematurity □ Yes □ No
- Renal Disease □ Yes □ No
- Family h/o Anesthesia Problem □ Yes □ No

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

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

Labs / Radiology (if pertinent):

Assessment (Medical / Surgical Indications for Admission):

Plan:

(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: __________________________