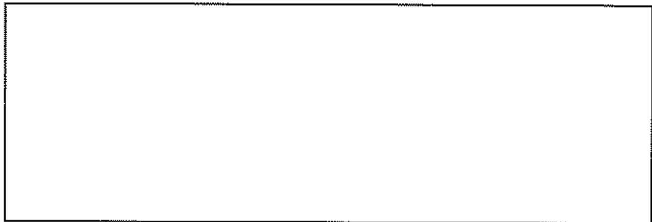


111 Michigan Ave NW
Washington, DC 20010

Surgeon's office to complete the following:
Fax completed form to: ____________________ *Date of surgery :* ____________________

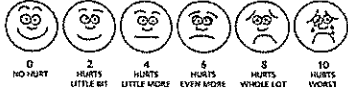
Contact your surgical scheduler or surgeon's office if the following:
Wheezing/cough in the past week Recent fever > 100.7°F or 38°C Pneumonia/flu in the prior 4 weeks

Surgical History & Physical - Interdisciplinary Patient Assessment

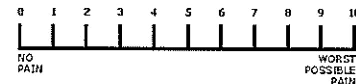
Chief Complaint: ____________________
History of Present Illness/Injury: ____________________

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

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



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 Disease	☐ Yes	☐ No	Congenital Heart Disease	☐ Yes	☐ No
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 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 →

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) ________________

□ 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: ____