Children's National Medical Center

111 Michigan Avenue, NW, Washington, DC 20010

Surgeon's office to complete the following:
Fax completed form to: _____ *Date of surgery :* _____
*Pre-op diagnosis for surgery:*_____ *ICD-9 code:* _____
*Proposed procedure:*_____

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)

Location: _____
Frequency: _____

Numeric Scale
(For older children and adolescents)

Duration: _____
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 GERD Congenital heart disease Heart murmur Prematurity: ____ weeks
Other:_____
_____

Family History/Psychosocial Assessment: _____

Allergies/Reactions: Yes No **Family h/o anesthesia problems: Yes No**
Bleeding Disorders / Tendencies: Yes No
If Yes to above, describe: _____

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

Current Medications: _____
_____

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:** _____

_____

Labs / Radiology (if pertinent): _____

_____

Assessment (Medical or Surgical Indications for Admission):

_____

_____

Plans: _____

_____

Education (*must be checked*):

☐ **Diagnosis, Medications, & Treatment Plan discussed and reviewed with patient / family**

I certify that this patient is medically cleared for surgery:

Resident/Fellow Signature:_____ **Print Name:** _____

(Mandatory) Physician/LIP Signature: _____**Print Name:**_____

Date: _____

24 Hour Update: My signature attests that indications and plans for surgery are unchanged.

Surgery Attending Signature: _____ **Date:** _____

Print Name: _____