PRE-ANESTHESIA PATIENT QUESTIONNAIRE

The following questions have been designed for use by the Anesthesiologist.
This questionnaire is to be completed BEFORE the operation.
Please answer each question carefully and return the completed sheet as soon as possible.

Child's Name: ____________________ Date of Birth: __________ Sex: M / F

Child's Weight: __________ Child's Height: __________

Please check that applies:	Yes	No	Don't Know
1. Has your child ever been admitted to hospital?	____	____	
2. Was your child born prematurely?	____	____	
3. Has your child ever had general anesthesia or surgery?	____	____	____

If "yes", where/when/why? ______________________________

____

	Yes	No	Don't Know
4. Did your child ever had any problems with the anesthetic?	____	____	____

If "yes", please explain: ______________________________

____

	Yes	No	Don't Know
5. Is there a family history of problems with anesthesia?	____	____	____

If "yes", please explain: ______________________________

____

6. Is your child presently taking any medication?

If "yes":

Name	Date Started	Reason for Taking

	Yes	No	Don't Know
7. Does your child have any allergies including drugs?	____	____	____
If "yes": What are they? ______________________			
Has the allergy required hospitalization?	____	____	____
8. Does your child have any damage/loose teeth or any dental work other than filling?	____	____	____
9. Has your child had a cold of cough within the last two weeks?	____	____	____
If "yes": Any associated fevers?	____	____	____
Is the cough producing mucus?	____	____	____
Associated with runny nose?	____	____	____
Associated decrease in their activity level and	____	____	____
appetite?	____	____	____
10. Does you child have cerebral palsy or any other neurological problem?			
If "yes": Seizures	____	____	____
Reflux or stomach contents?	____	____	____
Recurrent Pneumonias?	____	____	____
Aggressive tendencies?	____	____	____
Autism, Aspergers, ADD, ADHD?	____	____	____
Difficulty communicating?	____	____	____

Please Turn Over

Name: ____________

Date of Birth: ____________

	Yes	No	Don't Know
11. Does your child have asthma?			
If "yes": Is it presently requiring treatment?	____	____	____
Has it required admission to the Intensive Care Unit?	____	____	____
Has there been more than 2 bouts in the last 6 months?	____	____	____
Has it required oral steroid pills in the last 6 months?	____	____	____
12. Does your child have a heart problem?	____	____	____
if "yes"; what is it? ____________			
Has it required surgery?	____	____	____
Does your child tire easily?	____	____	____
13. Does your child have a muscle disease (such as malignant hyperthermia)?	____	____	____
If "yes", what is the diagnosis?			
14. Does your child have alow red blood cell count (anemia)?	____	____	____
If "yes", has it required treatment?	____	____	____
15. Does your child:			
Have history of easy bruising?	____	____	____
Have family history of bleeding problems?	____	____	____
Have history of excessive bleeding following a minor surgery?	____	____	____
16. Does your child have difficulty with head/ neck movement or mouth opening?	____	____	____
17. Does your child snore while seeping?	____	____	____
If "yes": Does your child stop breathing (sleep apnea) when sleeping?	____	____	____
Does your child have any problems with their tonsils?	____	____	____
18. Does your child have any medical problems that have not been addressed in the previous question?	____	____	____
If "yes", please specify: ____________			
19. Does your child smoke?	____	____	____
20. Do you or your child have any specific questions or concerns regarding anesthesia that you would prefer to address with an anesthesiologist prior to the day of surgery?	____	____	

21. Other Comments: ____________

Signature: ____________ Date: ____________

Parent / Guardian (circle one)

Telephone Number: Home: ____________ Cell: ____________

Work: ____________