dentTIVA 4729 Razor Creek Way, Louisville, KY 40299 (855) 266-3831 Fax: (855) 631-0417

Anesthesia Patient Health Questionnaire (Pediatric) Initial Here_____

Child's Name _____ Weight _____ lb. Nickname _____

Your Name _____ Address_____

Your Relationship to Child _____ _____

Your Home Phone _____ _____

Pediatrician or Clinic _____

Work/Cell Phone _____ Pediatrician Phone _____

Child's Medical History

1. Medication or Food Allergies:

☐ None Known

☐ Yes If Yes, to what? _____

_____

2. Medications:_____

_____

_____

3. Previous Surgery or Anesthesia

☐ None

☐ Yes (If yes, please write them): _____

_____

_____

4. Previous Hospitalizations:

☐ None

☐ Yes (If yes, please write them below)

At what age?_____

What hospital?_____

Reason for Hospitalization:_____

Procedure(s):_____

_____

_____

5. Any problems with anesthesia in the past?

☐ None

☐ Yes If yes, what happened?_____

_____

_____

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6. Is there a family history of anesthetic problems?

- ☐ None
- ☐ Yes If yes, what happened? _____

_____

7. Was your child premature?

- ☐ No
- ☐ Yes
  - If yes, how early?_____
  - What was the birth weight? _____
  - Birth place: _____
  - Was your child in a neonatal intensive care unit?
    - ☐ No
    - ☐ Yes If yes, how long? ___
    - Was your child on a ventilator
      - ☐ No
      - ☐ Yes If yes, how long?_____

8. Has your child been on an apnea monitor?

- ☐ No
- ☐ Yes If yes, is he/she on one now?
  - ☐ No If no, when was it discontinued? _____
  - ☐ Yes

9. Has your child ever had chicken pox?

- ☐ No
- ☐ Yes

Chicken pox vaccine?

- ☐ No
- ☐ Yes

Has your child been exposed to chicken pox in the past 3 weeks?

- ☐ No
- ☐ Yes

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10.

Medical Problems (check if yes and explain)

- ☐ Cough or runny nose in past month _____
- ☐ Fever in the past month _____
- ☐ Sore throat or hoarseness in past month _____
- ☐ Difficulty breathing _____
- ☐ Croup (barking cough) or stridor _____
- ☐ Asthma or wheezing _____
- ☐ Pneumonia _____
- ☐ Acid Reflux or Heartburn _____
- ☐ Aspiration or choking episodes _____
- ☐ Swallowing or Eating Problems _____
- ☐ Heart Murmurs or Irregular Heart Beat _____
- ☐ Other Heart Problems _____
- ☐ Nausea, vomiting or diarrhea in past month _____
- ☐ Recent weight loss _____
- ☐ Kidney Problems _____
- ☐ Liver Problems _____
- ☐ Hepatitis _____
- ☐ Previous Blood Transfusions; when was the last transfusion?_____
- ☐ Bleeding Problems _____
- ☐ Anemia or low blood count _____
- ☐ Sickle Cell Disease _____
- ☐ Seizures _____
- ☐ Thyroid Problems _____
- ☐ Muscle or Bone Problems _____
- ☐ Cerebral Palsy _____
- ☐ Developmental Delay _____
- ☐ Snoring or sleep apnea _____
- ☐ HIV / AIDS _____

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11. Is your child able to keep up playing with children of similar age?

- ☐ Yes
- ☐ No If no, please explain _____

12. Are there smokers in the house?

- ☐ No
- ☐ Yes

Is there anything else we should know about your child? _____

_____

_____

Signature of Parent / Guardian _____Date _____

END OF QUESTIONNAIRE

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