

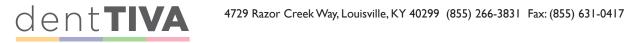
Anesthesia Patient Health Questionnaire (Pediatric)				Initial Here
Child's Name	Weight	lb.	Nickname	
Your Name	Add	ress		
Your Relationship to Child				
Your Home Phone				
Pediatrician or Clinic				
Work/Cell Phone	Pediatrician Phone			_
Child's Medical History				
Medication or Food Allergies:				
☐None Known				
Tyes 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?				
☐ Yes If yes, what happened?				

Initial Here

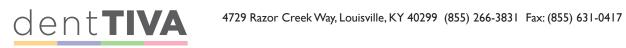


Anesthesia Patient Health Questionnaire (Pediatric)

6. Is there a fa	amily history of anesthetic problems?
□None	
Yes	If yes, what happened?
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-	hild premature?
□No	
Yes	and have and to 0
_	es, how early?
	at was the birth weight?
	h place:
	s your child in a neonatal intensive care unit?
]No
	Yes If yes, how long?
<u></u>	Was your child on a ventilator
	□No
	☐Yes If yes, how long?
8. Has your ch	nild 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 ch	nild ever had chicken pox?
□No	
Yes	
Chick	en pox vaccine?
C]No
]Yes
	our child been exposed to chicken pox in the past 3 weeks?
_]No
]Yes



Anesthesia Patient Health Questionnaire (Pediatric)	Initial Here
	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	
THIV / AIDS	



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11. Is your child able to keep up playing with children of similar a	ge?		
☐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