Preliminary Anesthesia Questionnaire

Today's date:_______________
Surgery Date:_______________
❑ Main Operating Room ❑ The Surgery Center
❑ Westerville Surgery Center ❑ Dental Surgery Center
Primary Language ❑ English ❑ _______________
Surgeon(s) Name _______________
Surgical Procedure_______________
Medical Record # _______________
Patient Name:_______________
Patient Birth Date:_______________
Primary Care Physician (Pediatric/Family Practice/Clinics):
____

Parent's/Legal Guardian Names: _______________
Best Daytime Number: (_____) _______________
Work Phone: (_____) _______________
Cell Phone: (_____) _______________
Email Address: _______________
Emergency Contact: _______________
Home Phone: (_____)_______________
Work Phone: (_____) _______________
Specialist or other doctors seen:
____

Please list your child's height _____ and weight _____
Has your child ever been diagnosed as obese? ❑Yes ❑No
BMI (Weight) screening: _______________
1.Does your child snore half of the time while sleeping? ❑Yes ❑No
2.Have you ever seen your child stop breathing while sleeping or gasp for a breath? ❑Yes ❑No
3.Does your child become tired easily? ❑Yes ❑No
4.Has your child started wetting the bed? ❑Yes ❑No
5.Did your child stop growing at a normal rate? ❑Yes ❑No
6.Is your child having problems at school? ❑Yes ❑No
Has your child ever been hospitalized? ❑Yes ❑No
____
Has your child ever had surgery? ❑Yes ❑No
____
Has your child or a family member ever had any serious problems with anesthesia? ❑Yes ❑No
If yes, what? _______________
Has your child ever been diagnosed with:
a heart problem or murmer? ❑Yes ❑No
high blood pressure? ❑Yes ❑No

Has your child ever been diagnosed with (CIRCLE ALL THAT APPLY)?
ASTHMA WHEEZING BRONCHITIS
CROUP PNEUMONIA
Date: _______________
Has your child taken oral steroids in the last month? ❑Yes ❑No
Is your child regularly exposed to tobacco smoke? ❑Yes ❑No
Ever had a seizure, brain, spine or nerve problem? ❑Yes ❑No
Does your child have a (CIRCLE ALL THAT APPLY)?
VP SHUNT BACLOFEN PUMP
NERVE STIMULATOR
Has your child ever been diagnosed with a syndrome, genetic disorder, muscle disorder or mitochondrial disorder? ❑Yes ❑No
Has your child ever had:
a stomach, liver or intestinal problem? ❑Yes ❑No
a kidney problem? ❑Yes ❑No
problems with unintended weight loss? ❑Yes ❑No

Has your child ever been diagnosed with diabetes: ❑Yes ❑No
a thyroid problem? ❑Yes ❑No
Is your child currently on any hormone therapy? ❑Yes ❑No
Has your child ever been diagnosed with:
a bleeding disorder, blood disorder or anemia? ❑Yes ❑No
Has your child ever received a blood transfusion?
If yes, any reaction?_______________ ❑Yes ❑No
Does your child bleed frequently or bruise easily? ❑Yes ❑No
Does any family member have a history of bleeding problem? ❑Yes ❑No
Has your child ever had a tumor or cancer of any kind? ❑Yes ❑No
Has your child ever recieved chemotherapy or radiation? ❑Yes ❑No
Was your child born prematurely? ❑Yes ❑No
Gestational age in weeks?__________
Was he/she admitted to the NICU? ❑Yes ❑No
Discharged home on oxygen? ❑Yes ❑No
Is your child developmentally delayed? ❑Yes❑No
Has your child been diagnosed with Autism Spectrum Disorder or ADHD? ❑Yes ❑No
List your child's medications? (include prescription, over the counter and herbal supplements) ❑NA
____
____
____
Has your child had any recent illnesses in the last month? ❑Yes ❑No
What symptoms did he/she have (CIRCLE ALL THAT APPLY)
FEVER COUGH DIARRHEA VOMITING RUNNY NOSE
Has your child been immunized in the last week? ❑Yes ❑No
Has your child been out of the country or plan to be out of the country one month before or after surgery? ❑Yes ❑No
Where?_______________
____
Are there any spiritual/cultural concerns that you wish to share? ❑Yes ❑No
Do you need an interpreter on the day of surgery? ❑Yes ❑No
What language?_______________

_______________ Signature of RN Review _______________ date/time