NATIONWIDE CHILDREN'S HOSPITAL℠

Preliminary Anesthesia Questionnaire

Today's date:_____
Surgery Date:_____
❑ Main Operating Room ❑ The Surgery Center
Primary Language ❑ English ❑ _____
Surgeon(s) Name _____
Surgical Procedure_____
Medical Record # _____
Patient Name:_____
Patient Birth Date:_____
Primary Care Physician (Pediatric/Family Practice/Clinics):
_____
Specialist or other doctors seen:
_____

Parent's/Legal Guardian Names: _____
Best Daytime Number: (_____) _____
Work Phone: (_____) _____
Cell Phone/Beeper: (_____) _____
Email Address: _____

Emergency Contact: _____
Home Phone: (_____)_____
Work Phone: (_____) _____

Has your child:

Ever had Surgery? ❑Yes ❑No
If yes, please list_____

Ever been hospitalized? ❑Yes ❑No
If yes, please list_____

Ever had any serious problems with anesthesia? ❑Yes ❑No

Ever had a heart problem or murmur or high blood pressure? ❑Yes ❑No
If yes, what treatment was/is provided _____
_____

Ever had a (circle all that apply)
- Respiratory disorder/airway disease or structural problem such as cystic fibrosis or narrowing of the airway? ❑Yes ❑No
- Tracheostomy ❑Yes ❑No
- Ever been on oxygen, ventilator, CPAP, Bi PAP Apnea Monitor ❑Yes ❑No

Ever been diagnosed with sleep apnea? ❑Yes ❑No
Ever used a sleep apnea monitor? ❑Yes ❑No

Ever had asthma, wheezing or pneumonia? ❑Yes ❑No

Ever had a seizure, brain, spine or nerve problem? ❑Yes ❑No
Does your child have a:
Shunt ❑Yes ❑No
Baclofen pump ❑Yes ❑No
Nerve Stimulator ❑Yes ❑No

Ever had a head or neck injury? ❑Yes ❑No
Any limitations with neck movements? ❑Yes ❑No

Ever had a diagnosis of a syndrome, muscle disorder or genetic disorder? ❑Yes ❑No

Ever had a stomach, liver or intestinal disorder? ❑Yes ❑No

Ever had a kidney problem? ❑Yes ❑No

Had any difficulty with chewing/swallowing or experienced unintended weight loss? ❑Yes ❑No

Ever had diabetes, a thyroid problem, a hormone problem or been on hormone therapy? ❑Yes ❑No

Ever had a blood disorder, sickle cell disease, clotting problem, Hemophilia, bone marrow problem or a blood transfusion? ❑Yes ❑No

Had a history of bleeding, bruising or nosebleeds? ❑Yes ❑No

Ever had a tumor or cancer of any kind? ❑Yes ❑No

Ever had chemotherapy or radiation therapy? ❑Yes ❑No

Taken steroids in the last two weeks? ❑Yes ❑No

Suffered from any illness recently? (e.g. fever, cough, diarrhea within the last 2 weeks) ❑Yes ❑No

Does your child have nursing care at home? ❑Yes ❑No

Does your child:

Have any depression of the immune system? ❑Yes ❑No

Take any medications? ❑Yes ❑No
(Please include herbal supplements and over the counter medication).
If yes, please list_____
_____

Have IV access (e.g. broviac, port or PIC line) ❑Yes ❑No

Have any allergies? Latex? Medication? ❑Yes ❑No
If yes, please list_____

Was your child born prematurely? ❑Yes ❑No

Is your child developmentally delayed? ❑Yes ❑No

Are there any spiritual /cultural concerns that we need to be aware of? ❑Yes ❑No

Please list your child's height: _____ and weight:_____

Family History:

Had a family member who has had a serious problem with anesthesia? ❑Yes ❑No

Had a family member with a bleeding or clotting disorder? ❑Yes ❑No

Any questions or concerns regarding this form, please call Pre-Admission Testing at (614)722-3850, between the hours of 8 a.m. and 4 p.m., Monday - Friday. Please return with scheduling information. Fax Number: (614) 722-4150.