PT Phone #_____ Facility_____

Parent's Name _____ Surgery Date_____ MAC / GA

Email _____ Pediatrician_____

Pediatric Pre-Anesthesia Questionnaire

Information you supply below assists in the development of your child's anesthesia care plan

Name_____ DOB _____

Age_____ Male / Female Height_____ Weight_____

Allergies _____

Please describe reaction to each medication allergy_____

_____

Current Medications (prescription, non-prescription, herbal supplements:

_____

_____

Prior Surgeries/Procedures: _____

Prior Hospitalizations: _____

Please circle "Yes" or "No" and write additional comments next to each condition

Any problems with anesthesia? **Yes / No** _____

Recent illness within last 2 weeks? **Yes / No** _____

Heart problem, murmur, or high blood pressure? **Yes / No** _____

Respiratory disorder / Airway disease? **Yes / No** _____

Sleep Apnea? **Yes / No**_____

Asthma / Wheezing / Pneumonia? **Yes / No** _____

Seizures / brain, spine, or nerve problem? **Yes / No** _____

Head or neck trauma? **Yes / No** _____

Diagnosis of a Syndrome / Muscle disorder / Genetic disorder? **Yes / No** _____

Stomach / Liver / Intestinal problem? **Yes / No** _____

Kidney problem? **Yes / No** _____

Difficulty chewing/swallowing? **Yes / No** _____

Diabetes / Thyroid problem / Hormone problem? **Yes / No** _____

Blood disorder (sickle cell, hemophilia, clotting d/o, blood transfusion)? **Yes / No** _____

Bleeding problems, easily bruising, frequent nosebleeds? **Yes / No** _____

Tumor or cancer of any kind? **Yes / No** _____

Developmental delay? **Yes / No** _____

Family history of serious problems with anesthesia? **Yes / No** _____

Family history of bleeding or clotting disorder? **Yes / No** _____

Any other condition not listed above: _____

Any special concerns or questions for anesthesia provider: _____

Fax: 773-442-1551 Email: Main3@quantumanesthesia.com