ARNOLD PALMER HOSPITAL
For Children
Supported by Arnold Palmer Medical Center Foundation

LINE UP PATIENT I.D. LABEL HERE

PREANESTHESIA QUESTIONNAIRE

Date: _____ **Current Height:** _____ **Current Weight:** _____

Check Yes or No to the questions below. If the answer is yes, explain on the blank lines provided.
NOTIFY THE STAFF IMMEDIATELY IF YOU HAVE GUARDIANSHIP BUT ARE NOT THE PARENT OF THE PATIENT.

1. Has the patient ever had surgery? If yes, list operations and dates:_____ ❑ Yes ❑ No
   _____
2. Has the patient ever had problems with anesthesia, sedation, or intubation?_____ ❑ Yes ❑ No
3. Is there a family history of anesthesia problems (high fever/malignant hyperthermia or prolonged muscle weakness/pseudocholinesterase deficiency)?_____ ❑ Yes ❑ No
4. Does the patient have any allergies (medications, food, latex, environmental)?_____ ❑ Yes ❑ No
5. Is the patient on any medications, herbal supplements or vitamins?_____ ❑ Yes ❑ No
   If yes, list name and dose: _____
6. Does the patient have any loose teeth, caps, bonding or other dental work? _____ ❑ Yes ❑ No
7. Has the patient had a cold, cough, fever or croup in the last two weeks? _____ ❑ Yes ❑ No
8. Does the patient have a rash? _____ ❑ Yes ❑ No
9. Does the patient bleed or bruise easily? _____ ❑ Yes ❑ No
10. Has any aspirin or ibuprofen been taken in the last week? _____ ❑ Yes ❑ No
11. Is the patient wearing contact lenses? If yes, please remove. ❑ Yes ❑ No
12. Has the patient ever had a serious illness including any hospitalizations?
    If yes, list what for and when: _____ ❑ Yes ❑ No
    _____
13. Does the patient have a syndrome or genetic disorder? _____ ❑ Yes ❑ No
14. Does the patient have seizures or epilepsy? If yes, how often?_____ ❑ Yes ❑ No
15. Does the patient have spina bifida or other spinal cord disorders? If yes, what level?_____ ❑ Yes ❑ No
16. Does the patient have a heart murmur or any type of heart problem? _____ ❑ Yes ❑ No
17. Does the patient have high blood pressure? If yes, what is normal for patient?_____ ❑ Yes ❑ No
18. Does the patient have asthma or wheezing? If yes, when was last episode?_____ ❑ Yes ❑ No
19. Does the patient have kidney problems? _____ ❑ Yes ❑ No
20. Does the patient have a history of cancer or a tumor? If yes, date of last chemotherapy:_____ ❑ Yes ❑ No
21. Has the patient taken oral steroid medications for more that five (5) days in the past 3 months? ❑ Yes ❑ No
    If yes, what, when and for how long? _____
22. Are there smokers in the home? _____ ❑ Yes ❑ No
23. Does the patient have a history of smoking, drug, or alcohol use? _____ ❑ Yes ❑ No
24. If the patient is <u>female</u>, has she started her period? Date of last period:_____ ❑ Yes ❑ No

Does the patient have any of the following? ***Please circle all that apply:***

Hydrocephalus	Liver Problems	Stroke	**Devices**
Cerebral Palsy	Sickle Cell Disease	Sleep Apnea	Shunt
Cystic Fibrosis	Sickle Cell Trait	Loud Snoring	Vagal Nerve Stimulator
Diabetes	Anemia/Low Blood Count	Reflux/Heartburn	Pacemaker/AICD
Thyroid Disease	History of transfusion	Frequent Vomiting	Apnea Monitor
Muscular Dystrophy	Immune System Problems	Arthritis	Baclofen/Insulin Pump
Developmental Delay	Other: _____		CPAP

Complete this section only if the patient is under two (2) years of age:

1. How much did the patient weigh at birth? _____
2. Was the patient premature? ❑ No ❑ Yes - If yes, how many weeks early? _____
3. Was the patient in an intensive care unit? ❑ No ❑ Yes – If yes, how long? _____

   If you answered yes to question 3, answer the following:

   A. Was the patient ever on an apnea monitor? ❑ No ❑ Yes – If yes, how long? _____
   B. Was the patient ever on a breathing machine (ventilator)? ❑ No ❑ Yes – If yes, how long? _____
   C. Did the patient have any bleeding in the head? ❑ No ❑ Yes

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PREANESTHESIA ASSESSMENT

Weight: _____ kg

History and Physical:

Exam:	Mallampati I II III IV
Airway:	Dental: _____
Lungs:	❑ Patient unable to cooperate with exam
CV:	

Previous Anesthetic History:

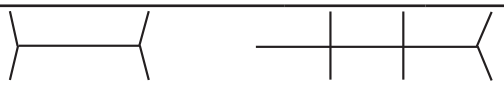
Medications:

NPO Status:

Milk & Solids at: _____ Clear Liquids at: _____

Allergies:

Diagnostics:



A.S.A. STATUS: _____ **bHCG-serum/urine:** _____

Plan: ❑ General Anesthesia ❑ Caudal ❑ Epidural ❑ Regional Post-op pain block: ❑ Caudal ❑ Regional
❑ Post-op PSCU/PICU ❑ Possible transfusion Invasive Monitoring: ❑ A line ❑ CVL
❑ Risks, benefits and alternative of anesthesia discussed with patient and/or patient's representative who understands and accepts plan; and all questions have been answered.

Signature_____ I.D.#_____ Date: _____ Time:_____

Post Anesthesia Note:

The post-anesthesia assessment was completed based upon the elements below. The patient is stable and has adequately recovered from the anesthesia unless otherwise noted.

	Yes	No	
Vital signs in patient's normal range	❑	❑_____	❑ N/A_____
Respiratory function stable; airway patent	❑	❑_____	❑ N/A_____
Cardiovascular function and hydration status stable	❑	❑_____	❑ N/A_____
Mental status recovered: patient participates in evaluation	❑	❑_____	❑ N/A_____
Pain control satisfactory, nausea and vomiting control satisfactory	❑	❑_____	❑ N/A_____

Comments _____

_____

Anesthetist: _____ I.D.#_____ Date: _____ Time: _____

Physician: _____ I.D.#_____ Date: _____ Time: _____