PEDIATRIC PREOPERATIVE ASSESSMENT FORM

PREOPERATIVE ASSESSMENT

Surgeon's Name: _____

Procedure/Surgery: _____

Screening Nurse/LPN: _____/_____

Patient: Please Complete (Name, Date of Birth)

Name: DOB:

Office Use: (Place Sticker Here)

FOR COMPLETION PRIOR TO PAC APPOINTMENT BY PATIENT, PARENT, OR LEGAL GUARDIAN

CURRENT MEDICATIONS: (**Bring a list of all medications, vitamins, supplements, drops you are currently taking; including herbal supplements):** _____

_____

ALLERGIES: (medications, latex, nuts, eggs, shellfish/type of reaction): ❍ **Latex Allergy**

_____

Prior Surgeries / Hospitalizations / Serious Injuries (bring separate list if space inadequate, include dates)

_____

_____

_____

QUESTIONNAIRE (Please answer whether the patient has had any of the following):

Prior difficulty with anesthesia or surgery? ❍ No / ❍ Yes
Had nausea/vomiting after surgery? ❍ No / ❍ Yes
Do you have any history with Malignant Hyperthermia? ❍ No / ❍ Yes
Difficult Intubation? ❍ No / ❍ Yes
Could you be pregnant? ❍ No / ❍ Yes
Date of last menstrual period: ___/__/____
Is there smoking in the home? ❍ No / ❍ Yes

Please fill in each that applies to the patient's medical history (i.e. "_____ have or have had the following"):

❍ Anemia
❍ High blood pressure
❍ Irregular heartbeat
❍ Heart murmur
❍ Heart surgery
(Date: __/__/__)
❍ Pacemaker/defibrillator
❍ Blood vessel disease
❍ Congenital Heart disease
❍ Recent cough/cold
❍ Asthma
❍ Emphysema (congenital)
❍ Exposure to cigarette smoke
❍ Home oxygen use
❍ Pneumonia
❍ Obstructive sleep apnea
❍ Loud snoring
❍ Bronchitis
❍ Tracheostomy
❍ Hepatitis/jaundice

❍ Other liver disease
❍ Steroid/prednisone use
❍ Kidney disease
❍ Kidney Failure
❍ Use dialysis (HD or PD)
❍ Stroke/TIA
❍ Seizure
❍ Syncopal/Fainting spells
❍ Paralysis
❍ Diabetes
❍ Insulin use
❍ Thyroid disease
❍ Juvenile Rheumatoid Arthritis
❍ Down syndrome
❍ Other syndrome:
_____
❍ Bleeding disease
❍ Hemophilia
❍ Sickle cell disease/trait

❍ Cancer
❍ Cancer with lymph node involvement
❍ Chemotherapy
(Treatment date: __/__/__)
❍ Radiation therapy
(Treatment date: __/__/__)
❍ MRSA/VRE
❍ Muscular Dystrophy
❍ Muscle disease
❍ Back problems
❍ Birth History
❍ Full-term
❍ Premature (How early?
_____)
❍ Neonatal ICU
❍ Intubation duration _____
❍ Oxygen duration _____
❍ Reflux/GERD/frequent indigestion
❍ Other: _____

ANESTH

Please check symptoms you have experienced within the past 60 days. Please fill in answers that apply.

GENERAL:	**NO**	**YES**		**GASTEROINTESTINAL:**	**NO**	**YES**
Good general health lately	❍	❍		Nausea or vomiting	❍	❍
Recent weight change	❍	❍		Frequent diarrhea	❍	❍
Weight loss in the last 6 months	❍	❍		Constipation	❍	❍
How much weight loss? _____		❍				
Were you trying to lose weight?	❍	❍		**GENITOURINARY:**	**NO**	**YES**
Loss of appetite?	❍	❍		Frequent urination	❍	❍
Fever / chills / night sweats	❍	❍		Burning or painful urination	❍	❍
Sleep problems	❍	❍		Blood in urine	❍	❍
MRSA / VRE exposure	❍	❍				
Attends Day Care	❍	❍				
				MUSCULOSKELETAL:	**NO**	**YES**
EYES:	**NO**	**YES**		Joint pain	❍	❍
Vision difficulty / Use glasses	❍	❍		Muscle pain	❍	❍
Blindness	❍	❍		Back pain	❍	❍
EARS / NOSE / THROAT:	**NO**	**YES**		**NEUROLOGIC:**	**NO**	**YES**
Hearing difficulty	❍	❍		Headache	❍	❍
Sinus problems	❍	❍		Localized muscle weakness	❍	❍
Nose or throat concerns	❍	❍		Numbness / tingling (hands/legs)	❍	❍
				Blurred vision	❍	❍
RESPIRATORY:	**NO**	**YES**				
Recent cough	❍	❍		**PSYCHIATRIC:**	**NO**	**YES**
Recent cold	❍	❍		Attention Deficit Disorder	❍	❍
Recent inhaler use	❍	❍		Depression	❍	❍
Wheezing	❍	❍		Anxiety / Nervousness	❍	❍
Snore at night	❍	❍				
				ALLERGIC/IMMUNOLOGIC:	**NO**	**YES**
ENDOCRINE:	**NO**	**YES**		Hay fever	❍	❍
Excessive thirst or urination	❍	❍		Hives	❍	❍
				Food allergies	❍	❍
HEMATOLOGIC/LYMPHATIC:	**NO**	**YES**		Immunodeficiency	❍	❍
Easy bruising or bleeding	❍	❍				
Enlarged glands or lumps	❍	❍				
Recent blood transfusion	❍	❍				

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

SIGNATURE OF REVIEWER: _____ **DATE:** _____